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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

THURSDAY, 28 FEBRUARY 2002

MELBOURNE

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 28 February 2002

Members: Senator Crowley *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Gibbs, Lees, McLucas and Tchen

Participating members: Senators Bartlett, Bishop, Carr, Denman, Evans, Faulkner, Harradine and West

Senators in attendance: Senators Crowley, Gibbs, Knowles, Tchen and West

Terms of reference for the inquiry:

For inquiry into and report on:

(a) the shortage of nurses in Australia and the impact that this is having on the delivery of health and aged care services; and

(b) opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses.

That the Committee specifically make recommendations on:

(i) nurse education and training to meet future labour force needs,

(ii) the interface between universities and the health system,

(iii) strategies to retain nurses in the workforce and to attract nurses back into the profession including the aged care sector and regional areas,

(iv) options to make a nursing career more family friendly; and

(v) strategies to improve occupational health and safety.

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Committee met at 9.00 a.m.

FARRELL, Dr Maureen Jean, Senior Lecturer, Department of Nursing and Midwifery, RMIT University

JOHNSTONE, Professor Megan-Jane, Professor of Nursing, Department of Nursing and Midwifery, RMIT University

KANITSAKI, Professor Olga, Head, Department of Nursing and Midwifery, RMIT University

MILLER, Ms Maria, Head of School, School of Nursing (Victoria), Australian Catholic University

NUGENT, Professor Pauline Margaret, Chairperson, Australian Council of Deans of Nursing

OATES, Ms Jennifer Mary, Acting Head, School of Nursing, Monash University

CHAIR—Welcome. The committee prefers all evidence to be heard in public but, should you wish to give any of your evidence or answers to questions in camera, you may ask to do so and the committee will give consideration to your request. We have before us your submissions numbered 192, 914, 458 and 725. Do any of you wish to make any alterations to the submissions?

Ms Miller—No.

CHAIR—We are going to have a panel discussion today, but first of all we are going to ask each of you to make an opening statement and then field questions. This may also allow you to comment on each other's comments.

Prof. Nugent—First of all, I thank the committee for the opportunity to present our information here today. As most people will know, there has been an enormous amount of scrutiny around nursing, particularly in relation to the acute shortage that we are facing at the moment. One of the positives that we have found out of this shortage and all this activity has been an enormous amount of research going on, particularly around the national review in nursing education.

One of the major findings that we believe has come out of that is a collation of the overwhelming evidence that—despite methodology, orientation or respondent—the university based undergraduate nursing programs in Australia are graduating large numbers of registered nurses who within three to six months seem to be functioning both confidently and competently in a complex health system. We would like to highlight that as coming out of many projects established over the last six months. When you look at the research around Australia and internationally you will see that Australia is recognised as leading the way with its education system for nursing and seen to be producing the outcomes and the numbers that are required.

There are several issues that I just want to highlight. I will try to go through them quickly. The first one is funding for clinical education, a major concern for nursing schools and faculties

around Australia. There are three issues related to the funding of clinical education. One is that it is very expensive. We find that the numbers of students that we have to put into the clinical environment, and the constraints on us around the ratios of one supervisor clinical teacher to eight students, cause enormous hardship within the schools and faculties. In particular, the hardship is faced by students and the clinical teachers, who might have to go into remote and rural areas to supervise students. The funding in the universities is no different to the funding of other disciplines that do not have this enormous clinical practicum that they have to undertake. It is a major concern for us and it has been for many years.

One of the issues also for us at the moment is with the financial constraints within the clinical environment. Some health care agencies and hospitals are starting to charge to have students within their clinical environment. Not only is that a financial hardship but we are also now facing the situation of not being able to access clinical places with the health care system because of the nursing shortage and also the attitudes of the field to having students within the clinical environment. The students are seen as a problem or a burden to the system rather than as tomorrow's employees and people who need to be nurtured and supported in their clinical education. Again, that is one of the concerns that have been around for a while, but it is now being exacerbated by the shortage in the clinical environment.

Another issue for us is transition. We feel that there is evidence that the schools of nursing around Australia are producing large numbers of registered nurses. However, within two to three years a large number of them leave the system. We feel that one of the problems that we have is the transition of the new graduate into the workplace. One of the issues related to that is the expectation of the field that the new graduates will hit the ground running and that they will then be seen as more experienced registered nurses within their first short period in employment, which is totally unacceptable and not expected of any other discipline that puts new graduates out into a system.

We believe that the transition program and the transition period are vital. Some states fund transition programs. However, one of the concerns that we have about that is that the funding that is made available in no way goes to support the students themselves; it virtually goes into the bottom line of the hospital's budget. If you have 10 or 100 students in the graduate program it really makes not a lot of difference to the amount of money that you get into the hospital to run those programs. We believe that the expectations of the clinical field in that transition year are also of major concern.

One of the other issues that we wanted to raise that has been highlighted by the National Review of Nursing Education is the respective roles of ENs and RNs. The research literature indicates that the RN is a much more efficient and productive worker within the health work force. We would certainly support the extension of the role of the EN; however, we would see it as replacing the unlicensed or unregulated worker rather than as a replacement of the registered nurse. We believe that would be very much a backward step within this country. At the moment the majority of the key peak groups in nursing would support a 70-30 split between the registered nurse and the enrolled nurse.

CHAIR—Is that 70 RN and 30 EN?

Prof. Nugent—That is right, yes. Another issue that has been raised out of the National Review of Nursing Education is tendering. This process has been put in place in England and in some areas in New Zealand: the government provide funds to the health service to then tender with universities to provide the education that nurses require for the work force within their organisation. We would vehemently oppose this process. It sets up enormous competition between universities, which I guess is not really bad in itself, however the competition is about undercutting each other to come up with the lowest possible tender price to offer the programs. We find from the research that the universities that usually win the tenders are then unable to provide a quality program for the price that they have tendered.

We also find enormous instability in the universities in that they can employ staff only for the period of the tender, and therefore cannot attract good staff. They also have a reliance on sessional and short-term contract staff, which again influences the attraction of students into those universities. It also provides an inequity for schools of nursing within universities, where they are seen as being unable to undertake the remit of the usual professions within universities—that is, education and research. There is no way in a tendering process that you can undertake a research program on the money that is provided for education only. Therefore you find that schools of nursing and faculties of nursing become teaching-only ghettos within universities and very isolated within that environment.

CHAIR—Is that an annual tendering process and to whom do they tender?

Prof. Nugent—They tender to the hospitals and the health services, and it is probably anywhere between a three- and a five-year tender.

CHAIR—Who pays?

Prof. Nugent—The Commonwealth would pay the hospitals. It has not been thought out very well, but I think the way it plays out in the new UK is that the national system pays the services to actually provide the money to the universities, once they actually go through the tendering process.

CHAIR—Thank you. That is worth following up. Prof. Kanitsaki from RMIT, would you like to make an opening statement?

Prof. Kanitsaki—In the first instance, we strongly support what Pauline Nugent has stated up to now. We have exactly the same views. Specifically, we are of the view that the causes of the shortage of nurses are probably in two areas. The first is that, as we found recently, in Victoria we could only produce 62 per cent of the 100 per cent of nurses that we are required to produce per year. Therefore, the production of nurses themselves is not adequate to cover the needs of the health system. This particular research will be published soon, I hope, and then it will be available to everybody.

The second major point—we think perhaps the greatest problem that exists—is that the current crisis in nurse recruitment and retention is has been driven more by poor working conditions in an outmoded hierarchal health care system, as has historically been the case, than by inadequacies of nursing education per se. I have been in the system for many years, and I have experienced this particular situation before in the 1970s and the 1980s, when the education

was in hospitals and we had exactly the same problems. At that time they tried to address the problem by education, and it was never fixed. We strongly believe that, even if we try to change the current education, the work labour force issues will not be resolved. We believe that, if we do change the educational model or whatever it is which is somehow negative, it will also destroy the educational sector, instead of just having the work labour force problems that we have today.

At RMIT this year, another issue that floats around is that we have not got enough places. We had an increase of 277 per cent in applicants over last year. We had 2,200 applicants in our university and we had only 199 places to give. We also had an increase of 144 per cent of first preferences over previous years. We have some ideas about why this has happened. One of the major factors that have influenced this particular move is the state government's publicity about the shortage of nurses. But, then again, that does not entirely explain the situation because across the state there was only a 16 per cent increase; at RMIT it was 277 per cent. We do not know why, but it happened.

We reject unequivocally any model of nursing education that would be tantamount to a return to the past apprenticeship style system of nurse training and would see students of nursing once again used as sweated labour of hospitals. I have trained in hospitals and I know exactly what is going on hospitals. I have worked in hospitals for 20 years. The current crisis in nurse recruitment and retention has been driven more, as I said before, by poor conditions. We believe also that the crisis of the present moment is caused not by education but by the financial situation. It is more a funding issue, rather than an issue of the education of nurses.

Any model of nurse education that has as its primary aim the rapid and expedient production of a cheaper, less qualified nursing work force will exacerbate, not remedy, the current nurse recruitment and retention crisis. There is much that is right about the current model of university nurse education in Australia, as Pauline has already stated, and it is critical that we consolidate the advances that we have made since 1985—while other sciences and so on have been around in universities for 200 or 300 years, we have made enormous progress in the nursing profession in such a short time—in the universities.

Expanding nursing education as a global enterprise would be of great economic benefit to the nation if it stays the way it is or if it is improved. We are not saying that it is perfect; we still have to make improvements and consolidations. I am sure you are aware that we export nursing knowledge to other countries and many nurses from other countries see Australia as one of the leading countries in the world for nursing education and they send their students to be educated here. It would be interesting to see what happens and how the national economy is improved because of this particular resource we have in Australia.

We are against suggestions of tendering in respect of nursing because we believe that would be a destructive process that would destroy entirely the education of the labour force and not assist with the current problems in the labour force. It would be worth while for the committee to obtain the state government's review on tendering to see what the state government has stated. They applied it here to maternity and child health nursing early on in the Kennett government and they realised in a very short time how destructive it was and they reverted to the old model.

We also support what Professor Nugent said about the clinical area. We really need support in that area. For example, RMIT pays for all the clinical hospital charges and that is a very expensive problem. Because of the shortage of nurses, we sometimes have to employ agency nurses and, as you well know, that is far more expensive. At the present moment, for one hour of clinical, we pay $41.14 whereas in 1985, we were paying $16 per hour. The funding formula in the university has not changed; it is exactly the same. When we employ an agency clinical teacher, we pay about $70—and sometimes up to $80—per hour.

The other issue that we would like to refer to relates to division 2 nurses. We support the articulation of division 2 nurses and we firmly believe that adding bits on to the education of division 2 nursing where modules of the registered nurse's curriculum are brought to division 2 nurses educates them in the TAFE system to enable them to do technical practice and so on. That is undermining the education of registered division 1 nurses. However, that is not the issue. It does not add to division 2 status or remuneration. They get no more money and their status does not change. They stay as division 2 nurses, but their burden is expanded. I believe that it is an exploitative model. I am not against continuing education for division 2 nurses. At RMIT this year, we had 500 applications from division 2 nurses to enter the registered division 1 nursing stream but we could not offer the positions because of the expense involved. We give them one year's credit so they can go directly to the second year and, because of the way the funding is organised, it balloons out and the process becomes very expensive. We would need that extra money to provide those places.

We believe that the transition from a third-year nurse to a practitioner in the health industry requires much more support. We require collaboration between the hospitals and the universities to ensure that the universities have some role in supervising clinical learning in hospitals. At the moment—and I am not sure how accurate this is—it appears that the graduate year that nurses are undertaking does not provide for their needs and that is why many of them are leaving. Even though a number of hospitals recruit for the graduate year, it appears that they are doing that more for financial reasons than for recruitment and retention reasons. That is all I have to say now. I will let the others have their say.

CHAIR—Can you answer one question to help us all: what is the difference between a mentor and a preceptor, let alone what either of them is?

Dr Farrell—I run a preceptorship program for Werribee Hospital here in Victoria. A preceptor is a person who undertakes some formal education in teaching and learning, and they supervise or take on a one-to-one ratio a graduate in the clinical area. It is normally for three months experience and they are the people who assess them. A mentor is very different. A mentor is more a one-to-one personal relationship where someone is being mentored to the next position. For example, Olga could be my mentor to become professor within the School of Nursing. A preceptor is more a supervisory position, on a one-to-one basis, but they do a formal assessment of the student.

CHAIR—We have a fair idea of what it means, but we want to know where the word comes from.

Dr Farrell—It comes from a Greek word.

Senator KNOWLES—Why aren’t they just called supervisors?

Dr Farrell—Within the nursing literature there is some confusion between what a mentor, a preceptor and a supervisor are.

CHAIR—Just when we have a grasp on it and we understand ENs and RNs, suddenly we have D1 and D2. On behalf of mere mortals like me, I would be extremely grateful for explanations. You said that RMIT pays for the clinical training. What does that mean?

Prof. Kanitsaki—It means that when we send students to the clinical placements, the hospitals ask us to pay money for supervising or teaching them. We pay them instead of somebody else—they actually charge nurses fees—for each group of students that we send out.

CHAIR—If the medical profession is doing their training in hospitals, and the university is funding a chair of something at that hospital, is it not also funded through the university?

Prof. Kanitsaki—I do not know about the medical profession.

CHAIR—I am just interested to know whether, if the university establishes a chair of surgery based in a hospital, it is funded by the university?

Ms Oates—No, it is funded by the hospital.

Prof. Kanitsaki—Yes.

Ms Oates—I am from Monash University, and those positions will be funded by the hospital.

CHAIR—We will need to get some further information on that because it is certainly an area of confusion. We have heard of chairs being established in hospitals, or shared between universities, and it is quite clear that we now need to ask: where does the funding come from? I would like a couple of points of clarification on this submission. We should proceed to hear from our other witnesses, but if there is anything you want to say which covers those things, the committee would be grateful for it.

Ms Oates—The School of Nursing, Monash University, thanks the Senate committee for the opportunity to appear before the committee and welcomes the inquiry into nursing. The school has over 600 students studying for a Bachelor of Nursing. Over 50 per cent of the course requires placement in health agencies and it has an overall annual enrolment of 1,000 to 1,200 students. The overall demand by prospective students for undergraduate places is strong and it continues to grow and diversify. Prospective undergraduate students are drawn primarily from three groupings: year 12 VCE students; division 2 nurses, usually with a TAFE certificate IV in nursing; and graduates from other disciplines. The last category, graduates from other disciplines, is an area of strong growth. Recognition of prior learning and credit arrangements for division 2 nurses have been in place for many years—probably six years—and are regularly evaluated and revised. Graduate satisfaction levels are higher for the Bachelor of Nursing and these are validated in annual graduate surveys in advisory forums with the industry.

The capacity of the school to meet increased demand by prospective students for our graduates is limited by internal university competition for HECS based undergraduate EFTUs. It is difficult to see that situation changing unless the Commonwealth government is prepared to pay closer attention to nurse work force planning, labour forecasts and the specific allocation of EFTU load. The school has maintained the primacy of the clinical component of the undergraduate course in the face of declining quality of clinical placements for students. The impact of staff shortages in the industry has directly contributed to the decrease in quality in quasi placements, and some units within health agencies have become learner hostile rather than learner friendly. In recent years, as they have struggled with workload issues, there has been staff dissatisfaction with working conditions and a perceived lack of reward for engagement in the teaching realm. Staff shortages in units have reinforced an expectation of graduates to hit the ground running which, in turn, affects the retention rates of new graduates.

Our graduates have well-developed general competencies in critical thinking, problem solving, and organisation skills as well as an excellent grounding in health disciplines. They are readily absorbed into other professions when workplace dissatisfaction leads to exiting from the nursing profession and some retraining. For instance, it is very common for us to have feedback that dissatisfaction leads to graduates of two years going to do a graduate diploma in computing, a graduate diploma in business, or a graduate diploma in education, even though they probably enjoyed their first year. They have options that perhaps those of another generation did not feel they had.

The crippling costs associated with clinical placements, where 20 per cent of DETYA funds are externally directed and considerable staff and infrastructure costs are borne internally—probably to the extent of around 35 to 40 per cent of all funds—impacts negatively on the capacity of the school to develop its research and scholarship base. I encourage the committee to address the costs of clinical nurse education for the universities, as they do for medical education. The committee is also encouraged to pressure the state governments to provide adequate levels of support to industry and establish accountability measures so that staff can resume an effective role in clinical education.

There are opportunities for the university and the health industry to develop closer partnerships in clinical education and in specialist education delivery. Options for multisite delivery of university based courses need to be explored more actively. The delivery of specialist postgraduate courses has been hampered in recent years by low and unstable enrolments, high costs to the university and students, and competition with other providers. There is a need for greater collaboration across the university sector and with the industry to meet work force needs. To summarise, at Monash University we are confident that we are currently developing value graduates. However, there is a considerable and unsustainable strain on the clinical education component. A great effort has been undertaken to develop postgraduate specialist education in a collaborative manner with industry, but there are many factors that militate against this. The resolution of workplace issues is vital to the health of nursing education. Your support for increased resources to clinical education would be enthusiastically welcomed.

To answer your question about chairs, within Monash University, for instance, most of the chairs are externally funded by the hospital sector, or through the state government or various other grants, not by the university itself. If we wished to establish a chair or a clinical school,

we would have to fund it ourselves. Our level of DETYA funding is completely inadequate to do that.

CHAIR—If you remember that comment about funding, which I might come back to later, and also if you hold in your mind the answer to the question, why did you keep referring to nursing as an industry when I thought for a long while the campaign was to get it known as a profession?

Ms Miller—Yes.

CHAIR—Don't answer that now, but I would like comments from all of you on that.

Ms Miller—I thank the committee for giving us the opportunity to speak. I speak on behalf of the School of Nursing in Victoria. As a university that is across three states and one territory, we have a school of nursing with a head in each state. Our school is committed to our central focus, and that is the education of graduates who are lifelong learners, professional, competent with an inquiring mind, and ethical in practice. We are committed to graduates who provide professional, safe care for all individuals, both indigenous and non-indigenous, and in all areas of nursing such as primary and curative health care. I will address some issues that I brought up in the paper. The first is why nurses are leaving the profession. The issues point to poor remuneration, poor working conditions, the stressful nature of the work—particularly now with the shortage of senior people within the health care sector who often leave to join the private sector—the physical demands of the work, long unsociable hours, poor career structure and a lack of opportunities for ongoing education. This is compounded in rural sectors such as where we have our second campus in Victoria.

The School of Nursing is concerned that increasingly it is suggested that the education of nurses be undertaken exclusively in hospitals because graduates would not be able to make decisions based on sound professional knowledge. We consider that this is a retrograde step that would lead to the deprofessionalisation of nursing. It is a point that we wish to make quite strongly to the committee. We believe, however, that the clinical setting is an integral part of undergraduate education. As my colleagues have said, clinical training is very costly. We are required by our nursing registering authorities to have a ratio of one to eight in the clinical environment. I believe we are funded on a model of one to 25. So we believe that there should be a substantial increase in funding for clinical training. The shortage of nurses in the workplace directly affects the clinical education of our students and the new graduate's transition to the workplace. At the ACU we try to employ our own clinical teachers, but at times we are reliant upon our professional colleagues in the hospital to take a supervisory role for a student while our clinical teacher may be in another ward. Commitment to our courses from all our universities is an integral part of having a successful graduate.

We believe that the number and availability of suitable clinical placements must be addressed. Universities are working hard, and in the last year the Victorian Deans of Nursing Group resurrected a committee of clinical educators and clinical coordinators, and we meet as a collaborative group to address the issues arising in the university sector. That group is working very collaboratively to try not to ask for all their clinical places at the same time of the year so that there is equity between universities. We are also committed to a four-year Bachelor of Nursing program. It is extremely difficult to have equity between all university students when

our students have a far bigger workload in order to complete a heavily laden three-year program. We want DETYA to provide adequate funding to the university so that we can produce graduates who will be safe working in an ever changing, highly complex health care system. Funding for clinical education should be transparent so that we know that it is earmarked, that it comes into the university earmarked and that it does not go into a black hole. We also need to ensure that a certain amount of money is given by state governments to health care agencies to support education. We would like that to be transparent and extended to other than category A and B hospitals.

We fully support an inquiry into an investigation of alternative modes of clinical education. There is more than one way to get a graduate, and that is why we have several universities in the state producing competent graduates with a different model. It is healthy, it is creative, and there should be a lot more talk between agencies and universities. As for recruitments and the number of graduates—I cannot speak for the whole of our university—in Victoria we took in 150 undergraduates last year. There were 50 at our rural campus and 100 at our metropolitan campus. We had an ENTER score of 82.4, and this year that number has gone up to 210. Applicants for this year numbered 1,400 and first preferences were approximately 512. You can see that there is demand in our organisation. We are currently running about 500 students full enrolment.

In order to attract more people, we have to have EFSU places allocated that are earmarked for nursing. Maybe there should be a moratorium on HECS fees for nursing courses or HECS exemption scholarships. Also, there is a variety of models of chairs in nursing. Some are jointly funded by the university and the health care sector, some are funded by benefactors and some are funded 100 per cent by the universities, but they are very few. It tends to be a collaborative model where hospitals or health care agencies provide the funds for that. That professor has full professorial rights within the university sector. They share their time between their duties in the university and their responsibility in the clinical area.

CHAIR—Thank you all for a feast of information. We will turn to questions now.

Senator KNOWLES—My first question is to Ms Oates from Monash University. I notice that on page 2 of your submission you talk about factors leading to nurses leaving the profession, and they include poor remuneration relative to other professions. Yesterday in Perth we had evidence that new graduates were getting about $32,000. It has been put to us that if one compares that with a whole lot of other graduates who go into other professions, it is not really a bad wicket. There has been much talk about the problem; there have been strikes about it. I realise there is a problem. Where do you look at the poor remuneration level cutting in?

Ms Oates—The retention issue is around 18 months to 24 months after exiting university. It is at that point. All of our VCE students come in with an ENTER score above 75, and many of them are over 80, which is the same score that is accepted by business and elsewhere. Usually around 18 months to 24 months, when they want a mortgage, they decide that they want an increase in pay and the career pathways are not there. The only way to improve their remuneration is to go through an agency, for instance. At that point, they decide that the remuneration in nursing is not sufficient. In the first year, yes, they are comparable with other graduates, but acceleration and attractive career pathways are not there for them.

Senator KNOWLES—What would they be earning at the end of two years?

Ms Oates—They would be earning $45,000.

Senator KNOWLES—A lot of people out in the work force do not get that, and that is the whole argument. I am not trying to devalue the role of nursing, because I admire nurses tremendously—I really do. But when we talk about comparative levels a lot of, say, 24- or 25-year-olds are not commanding anywhere near that figure.

Ms Oates—I will give you a comparative example. If they did a graduate diploma in business or computing, they would quickly find that their career pathways and remunerations would accelerate.

Senator KNOWLES—For some but not all.

Ms Oates—Nonetheless, they are there. Because of the pressure of the workplace, they discover that they have supreme organisational and problem solving skills. Once upon a time, perhaps because of the female nature of my generation, we would not have moved to another profession. It is a combination of salary, workplace conditions, high levels of debt from HECS and looking forward to the future and thinking, 'No, that is not where I want to be in 10 years.'

Senator KNOWLES—But others have a HECS debt too.

Ms Oates—Others will, but very often in an industry like computing, which I know quite well, the employer will bear the cost of much of that education at that point in time.

Senator KNOWLES—But we are whistling Dixie in a west wind if we think that is the norm. That is not the norm, is it?

Ms Oates—I am not so certain about that.

Prof. Nugent—I would like to make the comment that money always comes into it when you are looking at a dissatisfied work force. When we had our recruitment retention committee here in Victoria and surveyed the registered nurses who were choosing not to work in the work force we found that money did come into it, but it came in at about fourth. But when it is compounded by other issues, it becomes a bigger issue for them, because it is about the conditions that they work in, the stress that they are feeling within the work force and the fact that they do not feel valued or recognised for what they do.

Senator KNOWLES—By whom?

Prof. Nugent—By the community, by their fellow workers and by the interdisciplinary groups within health care.

Senator KNOWLES—That is a problem that has got to be addressed internally, is it not?

Prof. Nugent—Absolutely.

Senator KNOWLES—I would have thought that the community held nurses in very high esteem, particularly if they have ever been crook.

Prof. Nugent—They certainly do, and that has come out in many surveys. However, when they work in the system, nurses feel that as members of the multidisciplinary team they are undervalued.

Senator KNOWLES—Whose responsibility is it to give them some self-esteem? It is my responsibility to give my staff some self-esteem—to give them a pat on the back and tell them what good work they are doing.

Prof. Nugent—Absolutely. I believe it is the nursing profession's within the health system. It is about leadership, it is about how you work with staff to ensure that they have got a better environment.

Senator KNOWLES—So how do we change it?

Prof. Nugent—I think it is about leadership. I think it is about working with the middle leaders. What we find—

Senator KNOWLES—Who has to work with the middle leaders? I am trying to get to the crux of how we have to change—

Prof. Nugent—I think it is education. It is definitely management within hospitals. You find in a lot of environments that someone ends up in a unit nurse manager position because they have been a really good clinician, and all of a sudden they are managing staff and trying to ensure there is a work environment that is satisfactory to retain their staff.

Senator KNOWLES—That is not the responsibility of government to change, is it? Because government cannot legislate for personalities.

Prof. Nugent—It is not about personalities; it is about the management systems within hospitals.

Senator KNOWLES—But sometimes it is about personalities.

Prof. Nugent—All people have got personalities, yes.

Senator KNOWLES—As you say, they might be good at that job and as a consequence they get promoted into a job for which they are not ideally suited.

Prof. Nugent—But I am saying that that is the system that exists in the hospitals, and it is about how that gets impacted upon. Certainly, universities can educate our graduates to take on leadership roles and to be change agents, but I do not think it is fair that new graduates become the change agents. Some sort of process has to be put in place in the system. You are quite right: it cannot be a federal government approach. It probably needs to be a state government approach. We certainly have raised this with state governments, about how they work with the

industry that they fund to ensure that environments are established in the health sector that are conducive to registered nurses staying there.

CHAIR—Prof. Johnstone, did you wish to add some—

Prof. Johnstone—Yes, I did.

Senator KNOWLES—Can I clarify what I am getting at: is it unrealistic to suggest that the professional groups and organisations such as yours can lead from within, instead of asking governments to say, ‘You must be good to your staff, or else’? I think it really comes from within.

Prof. Nugent—I do not think anybody is trying to shift responsibility. I think it is a combination. Certainly we, as the Australian Council of Deans of Nursing, work with the Royal College of Nursing, the ANF and the Australian Council of Deans of Education, and all of us are identifying these issues and how we go about it. But we cannot do it without the management structures that exist in the hospitals working with us.

Prof. Johnstone—Senator Knowles, you are absolutely correct: there are issues of organisational culture. I think it really needs to be emphasised that one of the big problems is the nature of the outmoded and hierarchical cultures of organisations. You are correct that government per se cannot order change that needs to take place. However, drawing on the experiences of metropolitan health services in this state—where, for example, government has certainly provided very strong incentives to involve consumers and have consumer participation—there is no doubt that, had there not been some legislative incentive to force metropolitan health services to set up community participation groups, primary care groups and what have you to get that involvement, it would never have happened.

It certainly may not be the case that government at Commonwealth level could make the changes per se, but certainly at state level, with some incentive at federal level, incentives could be put in place to really force a relook at the organisational cultures which see nurses who are educated as freethinkers and responsible and as all the things that we would expect a modern thinking human being to be, and not come up against an outmoded style of management and a brick wall. We see everywhere—well, not quite everywhere—exemplars in private industry of work friendly places. I think the loud cry everywhere is that these places are no longer employee friendly—as if they ever were, I might add. It is just that people do not tolerate the oppressive styles of leadership—I should not call it leadership; it is misleadership—or oppressive styles of management which really do impinge on people’s willingness to keep fighting—

Senator KNOWLES—And on their job satisfaction.

Prof. Johnstone—and to keep struggling and on their job satisfaction. With respect to the remuneration, I would agree; it does come up, but it is low down. People say they are happy to work, and they do work—nurses have carried the system for years—but there comes a point when enough is enough. They are not willing to be tossed aside like worn-out things without recognition of the work that they do. With regard to the comparability, I wonder whether the

new graduates that you are comparing new nursing graduates with are truly comparable in terms of the work that they do, their levels of responsibility—

Senator KNOWLES—Double degrees.

Prof. Johnstone—and the stress that comes with the job et cetera. Maybe nurses are paid that because that is what they are worth, and we are certainly seeing interesting market indicators of what a nurse in industry is worth at the moment.

CHAIR—We heard yesterday of some nurses who are leaving Western Australia and flying to Victoria to receive $260 an hour.

Dr Farrell—That is correct. They can earn $1,200 in one shift.

Senator KNOWLES—We have all decided to take up the job!

Senator WEST—I am off to do a refresher course tomorrow!

Dr Farrell—These are in speciality areas—ICU—and through agencies.

Senator KNOWLES—Someone, I think it might have been Prof. Kanitsaki, mentioned that there is a shortage of nurses—and we all know that—and that only 62 per cent graduate. Is that what you said?

Prof. Kanitsaki—What I am saying is that we have done some research, using 1997 figures, into what would be required to cover 100 per cent of the workload in hospitals and so on. At the present moment, there is a graduation rate of 62 per cent in Victoria. In other words, we do not get the HECS places. We do not have the attrition. We graduate all of them, but we do not get the HECS places to get them in to produce them, so we are short 38 per cent.

Senator KNOWLES—Yesterday, Senator West asked what the drop-out rate is during university, and what the drop-out rate is post university—that is, once they get into a clinical environment and say: ‘Oh, is that the colour of blood? I don’t like that.’

Prof. Kanitsaki—I can only answer the university one, because honestly I do not know whether research has been done about post-university.

Ms Oates—We know.

Prof. Kanitsaki—I can tell you about our university. For example, the majority of students who drop out do so before 31 March in the first year. Then in the first, second and third years, we have an average drop-out rate of 2.5 per cent.

Senator KNOWLES—What is the first year?

Ms Oates—It is 20 per cent.

Senator KNOWLES—It is 20 per cent in the first three months?

Prof. Kanitsaki—Before 31 March, which is the cut-off date. We usually over-enrol for that, anyway, so we cover ourselves. We know they leave on 31 March, so we actually have HECS places there.

Senator WEST—Can I just clarify? 31 March is actually the date when they can withdraw from a course without losing any—

Prof. Kanitsaki—That is right, without losing their HECS money.

Senator WEST—Also, they can transfer to another course without incurring any—

Ms Oates—That is right. So it is nothing to do with drop-out in that regard.

Dr Farrell—But that drop-out rate is applicable to all university students—

Senator WEST—In all courses?

Dr Farrell—in all courses.

Prof. Nugent—There was some research done late last year into the drop-out rate of all university courses and nursing had the third highest retention rate in university courses of 78 per cent. Some courses, such as engineering, had a retention rate of 50 per cent. Nursing is above the average and always has been. When you look at the hospital based courses, in some states we had a 50 per cent drop-out. So we believe that we have a very strong and good retention rate in our university courses.

CHAIR—The question from Senator Knowles is interesting. If it is called ‘drop-out’ you have all explained, as has Senator West, that drop-out is not a good term; it is quite different from what happens six months later. It involves students settling into what they are going to accept and what they are going to do. But your figure of 78 per cent—

Prof. Nugent—It is 78 per cent retention throughout. That is across the country.

Senator KNOWLES—But the other question, in respect of which I do not think much research has been done, is what is the drop-out rate in the first 12 months post-graduate?

Ms Oates—We can answer that because we do our graduate surveys six to eight months afterwards and, again, the retention rates are very high and the satisfaction rates are high. So it is not occurring in that period of time. As you say, the retention rate in respect of the university is more of an issue if there is no drop-out. We cannot plan for any drop-out. However, the graduate surveys, which we receive at that point, also demonstrate that the graduates feel their courses are valuable and they are reasonably happy and supported at that stage. I can only talk for Victoria where there is a graduate program which supports them during that point. It is after that point where the dissatisfaction levels start.

Ms Miller—On anecdotal evidence from interviewing students who leave after their graduate year, and from talking to graduates in their fourth year or first hospital year, they say to us that they are going to go but they want to have that fourth year as the consolidation year. They feel that if they leave after that, if they want to come back to nursing at least they are consolidated. In some of their minds their graduate year, their first year of employment, is a continuation of their nursing education. The majority of people go through graduate year. They feel that they are not completing the course if they do not get a graduate year and are just employed as a non-graduate.

Prof. Nugent—The Australian Council of Deans has commissioned some research along the same lines as the supply and demand research that the Australian Council of Deans of Education puts out on a yearly basis. I am not sure if the senators are aware of that. It is a document that looks at completion rates, numbers of students going into courses across Australia and also separation rates from the work force across a period of time. That information, which we will probably be publishing within the next two months, shows that the majority of separations out of the work force for nurses occurs anywhere between four and six years after their graduation. Some of those return to the work force because they have left to have families and do around things around getting married and moving overseas. Some do come back, but some never come back. There is a majority of those at the moment. There has been a move in the numbers that are leaving through dissatisfaction in that period. They usually retain them in the first couple of years.

CHAIR—We have only a brief time and many senators and lots of questions. Can I ask if answers can be shorter. I am not suggesting anyone is waxing too eloquent, but perhaps we can sharpen it up.

Senator KNOWLES—I have a couple of questions. In your recommendations here, you have duplicated recommendations 20 through 36 which seem to be a repetition of recommendation one through to 18. Do not for one moment think I am being critical because these things do happen when there is a hiccup somewhere along the line. I was more concerned to know whether the recommendations 20 through 37 were actually meant to be different recommendations and they have been doubled up.

Dr Farrell—No. I was responsible for putting the document together. I probably repeated them because they applied to what I was talking about. They are not different. I apologise for that.

Senator KNOWLES—I just thought there might be another set of recommendations that have been left out there. In a practical sense when we talk about why people leave the profession, one of the reasons is the long unsociable hours of work. Given that people have the indecency to be sick 24 hours a day, how can anyone solve that problem when people have to be nursed 24 hours a day?

Dr Farrell—At the moment, because of the shortage in nursing, a lot of them have been asked to do double shifts. They will go to work and do a 16-hour shift and that is quite common in Victoria at the moment. They are so short-staffed that they ask people to do two shifts. A lot of nurses are doing that at the moment and that is where a lot of these long hours are coming in.

Senator KNOWLES—That would not be too flash for the nurse or the patient, would it?

Dr Farrell—It is happening in some areas. They just do not have staff so they ask people to stay on and do two shifts.

Senator KNOWLES—What is the state government doing about that? State governments, whatever their colour, seem to be notoriously laid back about problems like that. Have you had any recent negotiations with the state government to avoid such a demand being placed on the nurses?

Ms Oates—That is not something that the universities have been engaged in a conversation about but the research does show that there are much better practices that can be adopted. Sometimes you read that there are staff shortages all over the Western world, but there are many countries in Scandinavia where there is not an issue at all. One of the reasons there is not an issue concerns the organisational culture of good human resource management within the health sector, such as good rostering systems that suit the styles of the staff where they have time for planning their workloads, for instance. But they do sometimes require resources which I do not think necessarily they want to commit here.

Prof. Johnstone—As my colleagues have correctly pointed out, we are not privy to what is going on behind the scenes but we know, off the record, that there are very intense discussions going on with the state government. Today, for example, there is a very tense discussion going on about the issue of agency nursing and work conditions and what have you. So yes, those conversations are occurring very definitely.

Senator KNOWLES—So they are toe to toe all the time?

Prof. Johnstone—Yes. The issue is that there are holes and gaps that have to be filled. It is distressing to those of us who have been nurses for 30 years to still see the situation where nurses are being called in at five minutes notice to do night duty and what have you. This problem is exacerbated because of the shortage of nurses. Other nurses are getting extra pressure to work 12 hours instead of eight, et cetera.

Senator WEST—What is happening in terms of postgraduate study and access to that? I am wondering if we are talking about a lack of career path. Somebody mentioned someone going on to being a nursing unit manager and leaving the clinical stream. I am taking it that there is, as everywhere else, no clinical career path.

Prof. Kanitsaki—In Victoria, at least, we had created a clinical career pathway that came in with money to reward the clinical career, but it seems like it is not working very well. What the universities have started to do in Victoria—and I think it is going to work, particularly if we are very careful about what we do—is to have, for example, joint appointments with the hospitals whereby RMIT at least, and I am sure other universities do similar work, try to do three things. One is to change the culture within the wards so we actually have joint appointments sitting in the ward where the patients are and the staff are working. We are trying to improve the quality outcomes of patient care; to refine the nursing domain and improve and add to the knowledge of nursing by research; and to also create a career pathway for the nursing staff who actually can see someone in the clinical area who can get up from a lecturer or a senior lecturer to an associ-

ate professor or professor. We bring the academic and clinical roles in line by doing this. We are closely working with the management of the hospital and the management of the universities to ensure that we support that role in the beginning to ensure that it will work. That is one way that we are trying to develop some future for nursing in the clinical area. I think that particular person within the hospital can be an excellent role model for students and other clinicians who may have a particular area of expertise. For example, we have appointed somebody in acute aged care, where there is an enormous need for it. Somebody else may appoint somebody in critical care, for example, or children's nursing or whatever so other nurses can see how they can develop and take those opportunities.

Ms Miller—Industrially, in the year 2000-01 a certificate allowance was introduced in Victoria as a means of encouraging nurses to gain postgraduate qualifications. Each of us offers a variety of courses in collaboration with hospitals. They usually employ the students for four days a week and the students come to university on the fifth day. There was an initiative by the Victorian government last year to provide postgraduate scholarships to encourage more nurses in the workplace into postgraduate education. But if advertisements, internal and external to the health care sector, do not require that that applicant have a higher degree, why do it?

Prof. Nugent—Across the country one of the real problems is the lack of funding for postgraduate education. The majority of universities have gone to full fee paying for course work postgraduate education. Therefore there are very few Commonwealth funded places in higher education for specialist education across the country. There are some. Industries are actually paying the students funds to go into some of these courses. However, there are few incentives across the board. We do have some allowances in states but there are few incentives across the board for nurses to pay the money to do the postgraduate speciality education and then take on this specialist role.

Senator WEST—What sorts of fees are we looking at up front?

Prof. Nugent—About $8,000 for a 12-month graduate diploma. It is anything between $8,000 and maybe $11,000 or $12,000 depending on the university.

Ms Oates—I would like to add to that. Even where scholarships are provided, as they have been in Victoria recently, that uptake of those scholarships is much lower than they would want. The reason is that the staff have decided that they do not necessarily wish to continue with the burden of further study. Often they are quite weary from their work. There has not been the uptake there that they would have hoped for of scholarships to support them.

Senator WEST—What about refreshers? Say I have been out for 20 years and retire in June. What are you going to do to help me go back and relieve this problem? I have got general midwifery, mothercraft and community. They all keep saying they will take me, but I have not been in a ward for 30 years and have not worked in the community for 20. I am dangerous.

Prof. Nugent—You are dangerous at the moment but there are re-entry courses. They are available across the board in most states. They are linked to an educational component and then an extensive clinical component under supervision.

Senator WEST—How long have I got to support myself? What am I going to feed myself with while I am doing it?

Prof. Nugent—Not much.

CHAIR—Paid for by whom, run by whom and placed where?

Ms Oates—That probably has been part of a more successful strategy, the Victorian retention and recruitment strategy, where there have been a lot of mature age nurses who have returned to the work force taking re-entry courses. They are quite pleased with that result.

Dr Farrell—They get paid while they do it. Having said that, there is also a feeling that some of the people who are moving into the acute sector there are actually taking away from the aged care sector where they may have been working prior to that.

CHAIR—Are these places mainly in hospitals?

Prof. Nugent—Yes, mainly in hospitals.

CHAIR—And they are paid for by—

Prof. Nugent—The state government.

CHAIR—They are not really a university concern.

Prof. Nugent—Some are. My other hat is the Head of School of Nursing at Deakin University. We run re-entry courses that are university based linked with agencies. I am sure other universities do as well.

CHAIR—If Senator West wants to go to Deakin, will she have to pay?

Prof. Nugent—Yes.

CHAIR—She would be a drongo not to go to a hospital, wouldn't she?

Prof. Nugent—She would at the moment, absolutely.

Senator WEST—Also I do not live in Victoria.

CHAIR—There is no reason for you not to try. You can move.

Prof. Kanitsaki—There is a difference between the re-entry program and the refresher program. The refresher program is run by the hospital; the re-entry can be a combination of the hospital and the university. For example, we run re-entry in midwifery and general nursing, but we get half the money and the other half goes to the hospital. Clinical supervision gets the hospital the money, and the academic teaching side gets the other half, which is $1,000 or something—which really does not even give you the expenses, the money you are spending, but

we do it. The refreshers, however, are run by the hospitals. If you ask the state government, you may find out that they have not been very successful. Those refresher courses apparently do not improve the retention and recruitment situation—nurses will come back, but they do not stay anyway; they leave. That is the refresher courses, not the re-entry; the re-entry is different.

Senator WEST—How long does the re-entry take?

Prof. Kanitsaki—In our university they have to do four subjects and clinical, so it can be six months.

Prof. Nugent—Ours is 16 weeks.

Ms Oates—They are not run by the university. They are actually run by industry, and they can be as little as three months.

Senator WEST—So there is a wide variety in the standard of that, is there?

Ms Oates—There is a huge variety.

Senator WEST—Therefore a huge variety in the competency levels.

Ms Oates—Absolutely.

Senator WEST—And the confidence levels of the RNs at the other end.

Ms Oates—And in some cases, where the re-entry is run by some industry or professional groups, there is very limited value and very limited educational input.

Senator WEST—So there is another pair of hands, which would certainly do nothing to enhance the feelings of self-confidence and self-worth.

Prof. Nugent—That is right.

Prof. Kanitsaki—That is why they do not stay.

CHAIR—I am just sitting here listening to you all and realising that nurse education—re-entry, refreshers and retraining—is a dog's breakfast, and you would need a PhD to find out where would be the best place to go. Have you any recommendations on how you could simplify it for the poor ordinary people who want to return to nursing? Where do they go? Can they ring up somebody for an easy path through this mess?

Prof. Kanitsaki—Yes, they can ring the Chief Nurse of the state government—who actually started this particular process in Victoria—the Nurses Board of Victoria and the individual universities.

CHAIR—Can I ask about this interesting comment that I gathered from you, that you are all scrambling for clinical places. Was there ever a time when a university was attached to a

hospital, and only students of that university went to that hospital for clinical placement? None of you is old enough to remember the halcyon days?

Prof. Nugent—No, we are all far too young! There probably was a time very early on when that did occur. However, very few universities only linked to one hospital, even when they had the ability just to do that, because it is about providing the breadth of experience in the clinical environments for the students. So if you stay in one hospital you might not get all of that experience. One of the things that we are finding at the moment, though, particularly here in Victoria, with a large number of universities, is that some hospitals are dealing with all the universities and finding that very stressful.

So it is about how we link to specific hospitals, but there are two major problems with the preferred provider model—which is one university, one hospital. First, it certainly does not allow for the potential clinical places in that hospital to be used to their maximum, because other universities are not accessing that area. Second, it does ensure that the hospital has very limited access to graduates, because graduates will go where they have had experience in their undergraduate program. So if you are hospital X with university X, you will only have university X students wanting to come and be your employee.

CHAIR—Other witnesses have said to us, though, that they think there is a lot to be said for going to one hospital—you get a kind of brand loyalty. I am so old that I remember the days when nurses actually trained in hospitals, and the reputation of nurses in this country—and particularly this state, and some hospitals even more than others, one of which I studied at—was enviable around the world. What is more, those nurses were labelled ‘I’m a Royal Melbourne Hospital nurse’ or, if they were in Sydney, ‘I’m an RPA nurse’. There was a kind of brand pride. Do we not value this now?

Ms Oates—We would welcome more consistency there. To illustrate one of the worst examples of what is occurring, as part of the undergraduate preparation they are required to do a mental health placement.

CHAIR—Not too many people say, ‘I’m a Royal part-nurse,’ that’s true.

Ms Oates—The scarcity of valuable clinical placement means, for instance, that we are in a situation at Monash at the moment trying to find 70 places for 150 people. That sets up a competitive environment with the health agencies. In fact, a year ago we lost one placement which we had used for 20 years, because one university was paying a dollar more an hour. That was the level of thinking around that.

CHAIR—You have highlighted a problem. I understood that you meet as an organisation to try to rationalise the allocation of places for students.

Ms Oates—Yes**Ms Miller**—Yes.

Prof. Nugent—The only problem with that is when one university decides not to work in concert with the other universities and it organises an arrangement outside that. It leaves all the other universities very vulnerable. For instance, I have 600 students at the Burwood campus at Deakin. I received a letter from one hospital at one stage saying that they were going with only

two universities and would not be taking any of our students. We got that letter a week before a placement where we were sending a large number of students out. So there needs to be collaboration.

CHAIR—Indeed there does, but it certainly seems that you are highlighting problems of organisational culture between hospital and university. Who should do the arguing—you or the state government?

Prof. Nugent—I think it is us with the state government. I think that it is vital. We cannot do it by ourselves; we have to work with the state government. Certainly, we have made some inroads here in Victoria, but in other states there is probably some way to go.

Prof. Kanitsaki—It is extremely important for us to realise that we are producing a comprehensive nurse. We cannot rely entirely on the hospital clinical experience. We have to have a breadth of experience in the community of nurses because, as we know, the health care system is changing constantly. So we have to look at new ways of actually providing for clinicals. We can meet as universities to collaborate—I am sure we can do that; there is no problem there—and discuss with the hospitals how we can best utilise the clinical places available to get access for every university. We can also propose to establish virtual reality, technological centres—many other professions are looking at this; for example, in medicine they already utilise television and so on, to diagnose people in other countries—in which three-dimensional computerised programs prepare nurses before they go to clinical. We can reduce contact, but at the same time they can learn quite a lot.

CHAIR—The idea of nursing by virtual reality is something the committee will take on board. I want to move on. I know that my colleagues want the opportunity to ask some questions. To all of you who are burning to answer questions and have not had the opportunity, feel free to drop us a line. You have given us comprehensive submissions, and you are all busy—I am not asking for PhDs or anything like 30 pages—but send dot points if you feel you must.

The problem is that there is enough demand for people to go into nursing, there is somehow a loss of people two to six years out, and then there is the ‘get them back in’ challenge. As I read some of the submissions, the Victorian government has done extremely well at getting them back in, at least for the short term, and that seems to result from a combination of money, intent, creativity and the cooperation of all of you. Why won’t that be sufficient in the near future? What are you doing to say to the federal government, ‘We could actually teach twice as many nurses if we have the funding and places’? The country is screaming for more nurses, we have students piling up trying to get in, but we do not have the funding for the places. Is it simply a question of saying, ‘We need to educate more nurses and we need twice as many places’? Would the argument then be—I can be the education minister for the tiniest devil’s advocate opportunity—‘What is the point of educating more nurses? They will all drop out after three years.’

Prof. Johnstone—It goes back to the issue of organisational culture. It would be instructive to look at hospitals—they tend to be private—that have a high recruitment and retention rate and see what they are doing right. Compare those organisations with the public health system and we will see the gap: what they are doing wrong.

CHAIR—That would solve the problem of keeping nurses.

Prof. Johnstone—Yes, it would.

CHAIR—Do you want any more places in your universities?

Prof. Johnstone—Yes, we do.

CHAIR—Let us be clear that you want some more places as well.

Prof. Johnstone—Yes, and transparent designated funding for the clinical placements.

Prof. Nugent—One of the issues for us with universities, as you would know, is that they are deregulated to a certain extent. So even when you have got the profiles up and, for example, you have a profile of 800 EFTUs of nursing in one university, if a new course comes online that is a bit more interesting—biomedical technology, maybe—they will need some EFTUs for that course.

CHAIR—EFTUs?

Prof. Nugent—Effective full-time student units.

CHAIR—I do know that, but I am terribly pleased to have you spell it out. I mean, what is *Hansard* to do with a word like EFTU? It is very rude, actually.

Prof. Nugent—The vice-chancellor will say, 'we will just move a few off nursing' and over the years they have eroded the numbers in nursing by doing just that.

CHAIR—What is different between nursing and the department of English? Is there no faculty of science in universities?

Prof. Nugent—That is really one of the big arguments and I have had that argument in my university where they say, 'Why would we give more places to nursing? We will become a nursing vocational university and that is not what we want. We want arts and we want the breadth.' There is a degree of validity in that argument. You would need to look at the numbers across the country. You would not want one university to have 2,000 student units in nursing that overpowered the rest of the university—that would be difficult for any university.

Ms Oates—It is a complex issue. Five years ago, we lost a large effective full-time student load to other elements within the faculty in the university that were able to attract higher entry scores which had a larger potential research base. This is one of the problems that we have in nursing. For example, within Monash University, because it considers itself to be a significant research based university, with the lack of funding support for research in nursing, it is not necessarily seen as an attractive discipline to have within the university. One thing that has worked quite well was that, when there were targeted places for rural and regional campuses last year, we were successful in regaining some of the EFTUs that we had lost five years ago. But there has been significant slippage over the last five years.

CHAIR—Do you take any note of your colleagues in universities, the teaching profession? I actually did an inquiry into teaching a couple of years ago and had exactly the same conversation. Their fight was about getting universities to fund clinical placements in schools. I believe the universities did it but not to a sufficient amount. Isn't your fight just an intra-university brawl about getting more money?

Dr Farrell—Yes, it is, because with this funding weighting, nursing gets 1.6 and that was brought in by the federal government in 1991. Now, for education, the federal government just gives universities a big bag of money and they say that the university can do what they like with that. What has happened is that universities are still giving the 1.6 for nursing and that is a huge problem. We are trying to fight that at RMIT.

CHAIR—We are here on behalf of the Commonwealth so, while we are all terribly interested in the work practices that are actually creating a demand for nurses, our focus necessarily has to be on where the Commonwealth comes into this and where we can ask for recommendations. For example, as the nursing care in aged care is a Commonwealth responsibility, to what extent do you barter, bargain, and arm wrestle with the Commonwealth about places for nursing for aged care facilities? If you had not thought of that, please consider this idea.

Prof. Kanitsaki—We have and we are desperately trying to but, again, it is the money. At RMIT, we are already trying to establish a chair, at least, for aged care—particularly with cross-cultural issues, as we know that a lot of people from non-English-speaking backgrounds are ageing very fast and are actually far higher in percentages than the mainstream, if you like to call it that, in our society.

CHAIR—What success are you having and who is doing the arm wrestling? Are each of you doing it within the university or are the deans of the university arguing with the education minister that more nursing places are needed?

Prof. Nugent—As the Council of Deans of Nursing, we met with Minister Kemp and Minister Bishop. We had several workshops with Minister Bishop and her advisers and people from the aged care environment. With the places for nursing in universities, the message we got very clearly was that it was not an issue of getting more places to universities—they had them—it was about how we managed to get the places that were available within our university. So we were left to go back to our vice-chancellors—which is not easy, as my colleague from Monash has indicated. From the aged care perspective, one of the major concerns of attracting nurses into aged care and postgraduate specialty courses is the difference in salaries provided to nurses working in the aged care environment compared with the state-funded acute care environment. We are battling with that at the moment. It is not an area that nurses are choosing to go into.

CHAIR—Can you provide for the committee data referring to drop-out rates of nurses who are two, three, five or seven years into nursing?

Prof. Nugent—We can give you that across the country and broken down state by state.

CHAIR—That would be extremely valuable, thank you very much.

Ms Miller—With regard to aged care, I totally agree with Professor Nugent. There is another matter within aged care and that is that the number of division 1 nurses, or RNs, in this sector is minimal. The reason many give us for not staying in the area is that they are concerned about being in a position of supervising unregulated workers. They choose not to have that stress. It is not unusual for one RN to be responsible for over 100 residents. Our university is committed to aged care. We have an ageing population, and recently the Sisters of Charity and the Sisters of Mercy, Health and Aged Care funded a chair in aged care.

CHAIR—Why do you keep calling yourself an industry when the struggle has been to be recognised as a profession? This goes to Senator Knowles's question about the status of nurses and how they are seen, or think they are seen.

Ms Oates—When I was referring to an industry, I was really referring to the negotiations we have over the clinical placements. We would regard ourselves as having those negotiations with our industry partners rather than with their profession, partly because it has become a very economic issue. I would just like to highlight an issue that you raised before about increasing the number of effective full-time students, which would certainly be helpful. Nevertheless, with that has to come the ability to provide quality clinical education. The other thing is that it is probably true—Professor Nugent might like to comment on it—that there were some difficulties in providing good strong nursing leadership in the 1990s, when we lost a lot of substantial nursing leaders.

Prof. Johnstone—Again, supporting my colleagues, we most definitely see ourselves as a profession and not an industry. We have enormous battles within the university sector for them to understand that we are taking a professional stance, not an industry stance, but we are put under a lot of pressure to be advocating our arguments in industrialist terminology.

CHAIR—I am interested in the challenge you have, first of all for clinical placements and the funding for that. Do you have any information that you can give us about who pays for the clinical time? Universities work for six months of the year. There is a lot of time when the academic teaching of the universities is not available to students, so there is the prospect of extending the time for teaching and clinical experience in hospitals. I think we must, in a very brief comment, get some response to that. The other concern I have is that if universities are not paying for the clinical experience, who is?

Ms Miller—The universities are paying for the clinical experience of their students. They either pay the hospitals directly for supervision or they employ their own supervisors to do so. The problem is that the funding that the universities get to fund clinical is totally inadequate. That has an impact on the number of HECS places that universities allocate to nursing, because it is a very expensive course with the clinical component, which is not funded adequately.

Ms Oates—The state government provides an allocation to the hospital for undergraduate nurse education, but it is not tied and there are no real accountability measures there. So, for instance, as Professor Nugent commented earlier, if one won a health agency and it does not go to private organisations, and if it takes 20 students it will get the same allocation as it would have taken if it were taking 2,000 students. There is no guarantee either that that money would be concentrated for nurse education.

CHAIR—There are a couple of questions I would like you to take on notice. They are on the role of registration bodies for nurse registration. Is there only one body? Are there some? You have universities setting curriculum, hopefully in conjunction with the profession. There are hospitals trying to demand that certain things are taught and not taught. Then there are nurse registration bodies actually having another finger in the pie. There is reference to them here, but I do not have sufficient information. You can either point us to a place where there is information or drop us a brief extract—half a page would be fine, if you can do it in that, or even a flow chart—showing how these things get together. It seems to be something of a tangle. The trouble is that, when you finally get sorted out who is doing what, behind that comes a funding brawl about getting adequate recognition of what is required for registration for clinical teaching. What pressure does that put on the universities or how can it be used to support your case? That is a matter of concern for me.

I would appreciate the contribution you said you would provide in comparative information on drop-out rates around the country. Do you have any further information or comparative data between one state and another? Are nurses pouring into Victoria because you pay more? I appreciate very much that, from the Victorian figures, we now have a sense of what the size of the hole is and how the Victorian government—in collaboration with all of you—has fixed the problem in the short term to some extent, but it has cost a lot of dollars. Data is very welcome. What is the size of the nursing shortage? If you have the information for Victoria, that is a help; if you have it for the nation, that is even better. Do you have any little maps that would help us to understand the answers to Senator West's questions about where you go to get back into the system, who is funding it and whether that could be improved? Finally, I am very interested that you mention research. I think it is very important that the profession stick in there and hang around until they get really sexy and people value the research they do. But, if you ceased to exist, the country would know about.

Senator GIBBS—Ms Miller, in your submission you were talking about the three-year degree course being increased to the four-year degree course. Is that a popular notion? Does that have a lot of support?

Ms Miller—Yes, absolutely.

Prof. Kanitsaki—Absolutely.

Prof. Johnstone—Yes.

Ms Miller—I believe DETYA have said in the past that we can all run a four-year degree if we wish and they will fund us for three. We are barely being funded now for three and we could not do the fourth year.

Senator GIBBS—Yesterday when we were in Perth one of the witnesses suggested that we have a four-year course but he also suggested that, due to the problem with retention, after a while a lot of nurses think that nursing is not for them. He was suggesting that maybe six months of training could be hands-on training within the hospital. That would have to be at the beginning to see if they actually liked doing the things that they had to do and could put up with them. Would all or any of you agree with that?

Ms Miller—I can only talk for me personally. We try and get our students into the health care environment as early as possible. In fact, they go in for observational visits in first semester. But I think that, to safeguard the public, you must have students going out who have a certain knowledge base. I think it would be unsafe practice to put them into the hospital sector for the first six months of their undergraduate degree.

Prof. Nugent—Particularly in the environment that exists at the moment, which is not necessarily conducive or supportive to the student as a learner. Deakin also put their first years out in the field. We have had some research done on the impact of that first year experience. It is fairly negative because of the hostile environment they see themselves going into and the fact that they feel that they are unable to do things that registered nurses within the work force expect students to be able to do. It is a bit of a balance.

Dr Farrell—The six months should be at the end of the course where they consolidate their practice.

Senator GIBBS—It could put them off more than encourage them.

Ms Oates—Yes, if a student has an unhappy clinical experience. We will find definitely that we will have retention rate problems within the university if we expose them to that form of risk. The other thing is that in many situations the clinical environments they go into if they are in mental health can be aggressive and they have to have the skills and capabilities to deal with that.

Senator GIBBS—Yes, I understand.

Prof. Johnstone—I have been involved in focus groups with students and—in support of Ms Miller's comments—the students absolutely valued the opportunity for observational experience. It may come as a surprise to us, but many of these young people have never been inside a hospital, so they have actually never been in that environment and have no idea—

Senator GIBBS—They are very healthy.

Prof. Johnstone—and they said that for some of them it was a completely new experience to walk inside a hospital and that an opportunity for observation would help them enormously to be able to make a decision as to whether that was what they wanted to do.

Prof. Kanitsaki—One point more: if you look at the drop-out rate or the non-retention rate in the universities, the issue is not that they are leaving the educational system after 31 March; it is before that.

Senator GIBBS—I understand that. It is a few years down the track.

Prof. Kanitsaki—Therefore, putting them in in the first six months, the first year, actually puts the system in danger or at risk; you do not gain anything out of it because it does not make any difference to them staying in the profession or not. But at the end it would.

Senator GIBBS—That is right and I agree. It was my understanding that it is the retention rate down the track, after they have been working in the profession, because, if they do extra study, postgraduate work, and get a postgraduate degree, there is no extra money for doing that. So they are not recognised for their study work, the work that they do and the knowledge that they have.

Prof. Kanitsaki—Do you realise that in Victoria they have changed the laws recently and they do actually give them some money if they have a graduate diploma, a masters or a PhD—so they encourage them to do so.

Senator GIBBS—Thank you very much. Ms Miller, in aged care you said there was one registered nurse to what number of patients?

Ms Miller—It is not unusual that there may be one registered nurse responsible for up to 100 residents in aged care. I cannot provide you with documented evidence but, anecdotally, that is not unusual, and it is very difficult to get division 1 nurses, registered nurses, working in an environment where they feel patient care is compromised.

Senator GIBBS—Is it a problem for registered nurses to work in aged care facilities because the positions are not there?

Ms Miller—The positions are there but there are difficulties in attracting division 1 nurses. As Professor Nugent said, the funding for division 1 is different in aged care from what it is in the state system. The issue of professional accountability and concern for the individual in the bed is another reason for them not being attracted to that area.

Senator GIBBS—Are their wages lower?

Ms Miller—Much lower.

Dr Farrell—Thirty per cent lower than what you can get in the acute care sector. That was in the paper yesterday.

Senator TCHEN—I apologise for not being here to hear your initial comments. Unfortunately, with the start of the Grand Prix, there is a truck blockage in Parliament Square. It is not the best time to travel in Melbourne. I have a number of standard questions which I intend to ask all the witnesses, because they are fairly fundamental to the committee's coming up with some worthwhile recommendations. Having heard some of your comments and having read your submissions, I think you have covered most of them already, but I put these questions to you in case you wish to add anything. It seemed to me that the terms of reference of this committee are based on a series of assumptions and an assumed truth. There may be a variation and people might see it differently. Firstly, it is assumed that there is a shortage of nurses; secondly, that the meaning of that shortage is a grey area, particularly across the different sectors of nursing practice; thirdly, it is assumed that there is a solution to the shortage; fourthly, it is assumed that the solution can be provided through education and training—again, I think you have covered that already—and, fifthly, it is assumed that the solution has to be provided through government efforts and can only be provided through government effort, specifically Commonwealth government effort. Professor Nugent's written submission states:

It is an idealistic, altruistic occupation when idealism and altruism appear to be in decline ...

If we focus on that, it will give us a long-term solution to any shortage problem. I do not know whether you ladies wish to comment on any of the points that I raised, because, as I have said, I think you have covered them already. Some other submitters were more narrowly focused and will raise more interesting questions.

Ms Oates—I draw your attention to what I said about Scandinavian countries where there is no so-called nursing shortage and no crisis in health care. One of the reasons for that is that the right to health care, the funds spent on health care, support from the organisational culture and issues of organisational culture have been addressed. It is more a UK-Australia system. Different principles have been underpinning the health professions and health industries.

Senator TCHEN—That is something that I noticed in your comments. Would you care to provide the committee with a more detailed description of what you see as the advantage of the Scandinavian system—not now, because it is obviously not a simple answer. I also have one comment that I would like to ask you ladies to take on board. When we are talking about the shortage of nurses, training and the nursing profession, it seems to me that there is the assumption that nursing is a preferred—I use the word very carefully—female occupation. On both sides of the table there is the assumption that it is a preferred female occupation. For example, one of the suggestions in the terms of reference refers to creating a more family friendly environment. In your submission you talk about child-care provision. It seemed to me to be based on the assumption that most nurses, by preference of the provider and the students—

Prof. Johnstone—Could you please clarify what you mean by ‘female preferred’, because I am not sure that I understand your point.

Senator TCHEN—In your submission and also, perhaps, in the deliberations of the committee before this inquiry started, there is the assumption that ‘nurses’ mean ‘female nurses’.

Prof. Johnstone—May I respond to that? The fact is that 94 per cent of nurses are female. That is a fact. Historically, it has been higher than that. There has been some increase in the number of men in the profession. I can speak on this quite authoritatively, because I have done work on this. The interesting thing is that the majority of men—and I think the figure is something like 60 per cent of the 10 per cent—are in the upper echelons of the profession and are not really carrying that burden of work on the floor that female nurses are carrying. Whether we like it or not, women do carry the majority of the burden of child caring responsibilities—even with SNAGs.

Senator TCHEN—I am not challenging that female—

Senator WEST—Have you done work on the career pace of those males as opposed to the career pace of females?

Prof. Johnstone—Yes. They constitute less than 10 per cent of the profession, but occupy 65 per cent of the upper echelons, the top jobs.

Senator WEST—And they get there quicker.

CHAIR—Senator Tchen, we are at the edge of time—already late—so get to your question quickly.

Senator TCHEN—Professor Johnstone, my question to you—and perhaps you ladies might like to make a written submission on that as well—is a series of 'why?' For each of those points you raise, why?

Prof. Johnstone—I can send you a book.

Senator TCHEN—It seemed to me that one of the problems that we might face is that if any profession or occupation is limited to one gender only, then immediately you exclude half of the potential work force. I am not saying that you deliberately do it, but I am asking why it happens.

Prof. Johnstone—Men do not tolerate the conditions that women do.

Senator TCHEN—Professor Nugent, I am interested—and this is a sideways question—in your reference to the study of university course retention rates. This does not strictly have much to do with this inquiry. You said that nursing courses had 70 per cent retention rates—

Prof. Nugent—I said 78 per cent.

Senator TCHEN—So 78 per cent, which is the third highest, and engineering is about 50 per cent, which is the lowest.

Prof. Nugent—That is the lowest.

Senator TCHEN—Was there any correlation between the retention rate and the entry scores?

Prof. Nugent—I do not think they went into that, but there is a study being done at the moment here in Victoria, commissioned by the department, looking at ENTER scores, first preferences, number of positions in each university, drop-out rates and completion rates. Our gut feeling is that the ENTER scores do not make a lot of difference, and I think there has been some research recently—not about the drop-out rate—that shows that the achievement of students in university courses is definitely not correlated to the level of their ENTER score.

CHAIR—There are some questions I will ask you on notice. The first follows the question from Senator Gibbs. Why would you go to a four-year course, which would be expensive to the universities, when you could leave it as is and get the hospitals to pick up the cost of intern training, in the way the medical profession has been going, for example? In a word or half a paragraph you might want to comment on that. Also, Ms Miller, you have actually given me about 5,000 questions, but I ask one on notice. On page 5 of your submission, with regard to return-to-work nurses, you say:

> ... preventing hospitals from providing incentives to nurses to return to the work force and thus decreasing the diversion of funds that are desperately needed elsewhere ...

I would like you to comment in writing on that paragraph, particularly because I would like to ask: what funds are you talking about and where do those funds come from? Hospital funds are not a diversion of university funds—at least, not an easy diversion—but if you are talking about that, I would welcome some comment on it. Also, perhaps someone could comment very briefly on the line that it is not good to establish a war between universities and hospitals, particularly if that means fighting for precious dollars.

I understand what you all say, and the sentiment we have received across the country is that there is no desire to return to the apprenticeship-type education of nurses, as we have known in the past. However, a lot of nurses say that they welcome access to training and retraining in the clinical situation; they are terribly happy to go back into a hospital and do their refresher and registration courses, and they are very loath to go out to universities which may be remote and difficult for them to cope with—that is, remote from the clinical setting—and they want to get back to hands-on learning. If you would care to comment on that, please do. I am afraid that we are out of time and I have to ask you to take those questions on notice. We would appreciate your comments, but please feel free to be brief.

Proceedings suspended from 10.45 a.m. to 11.05 a.m.

CERASA, Ms Debra, Nursing and Operational Support Director, Latrobe Regional Hospital

COLLETTE, Ms Julie, Director of Nursing, Mercy Hospital for Women

CROWE, Mr Shane, Nurse Unit Manager, Neurosurgery Unit, Austin and Repatriation Medical Centre

DRISCOLL, Mrs Andrea, Course Coordinator of Graduate Certificate of Intensive Cardiac Nursing, Austin and Repatriation Medical Centre

HANCOCK, Ms Jennifer, Nurse Unit Manager, Intensive Care Unit, Austin and Repatriation Medical Centre

KENNEDY, Mrs Diane Margaret, Manager OH&S/Recruitment (Nursing), Latrobe Regional Hospital

PETTY, Mr Mark, Executive Director of Nursing, Austin and Repatriation Medical Centre

VALENTINE, Ms Teresa, Professional Development Manager, Mercy Hospital for Women

CHAIR—I welcome representatives from the Latrobe Regional Hospital, the Mercy Hospital for Women and the Austin and Repatriation Medical Centre. The committee prefers all evidence to be taken in public but should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration of your request. We have before us your submissions Nos. 751, 801 and 920. Do any of you wish to make alterations to your submissions? If not, I ask each of you to make a brief opening statement. I apologise for being a bit late. Some of you could see how interesting it is, so we are sorry for a slightly delayed start. If you could therefore keep your opening statements sharp, we can have more time for questions.

Ms Cerasa—The submission from Latrobe Regional Hospital represented the combined thoughts of a group of senior nurses from a variety of our clinical and specialist settings. Rather than looking at a statistical data and research approach, the group wanted to highlight their perception of the issues with nursing that they felt were facing the profession, especially from a rural setting. They approached it with grassroots level thought and they looked at the issues that they saw as real issues within a local rural community.

Ms Valentine—The Mercy Hospital for Women thanks you for giving us the opportunity to give evidence to the committee. In putting the submission together, we also took into account the culmination of wide consultation with the nursing staff at the hospital. This was inclusive of the midwives at the hospital who are a major component of the nursing division, accounting for about 70 per cent of our staff. Probably the major points in our submission and the things that the staff in consultation really wanted us to bring to this committee were the issues regarding the national consistency of education and registration, the midwifery issues related to direct

entry for midwives and the inequity of funding issues, which is an enormous problem in terms of the clinical and university setting in terms of having funding for nursing education activities. Finally, but not least, one of the most important issues is the lack of leadership that exists across the nursing areas and the funding available to support the development of leadership mentoring and preceptorship skills.

Mr Petty—The Austin and Repatriation Medical Centre is one of Victoria's large public hospitals with over 750 beds. It acts as a major teaching and research hospital affiliated with the University of Melbourne and La Trobe University. We provide a wide range of services including acute health, rehabilitation, psychiatry and aged care. We are one of the principal service providers to Victoria's veterans' community. Similarly, our submission was developed with extensive consultation with our staff across a range of forums including our registered nurses, nurse unit managers and our nursing services management.

Our submission highlights a range of issues and I will highlight some of our major recommendations. One of our major concerns is the representation of nursing at a national level. We believe an important consideration would be the development of a national nursing body with the Commonwealth nursing officer at its head. The standardisation of registration across Australia is a major issue with different state registrations and it is an issue that we deal with on a daily basis. The allocation of funding for both education and developmental programs with adequate clinical support is an important issue that we highlighted in our report and the development of undergraduate curricula with a view to funding clinical experience is also a major element in our submission.

Senator GIBBS—It seems that in all of your submissions, we are always talking about the lack of funding and problems with education. The previous witnesses were saying that the three-year degree should be a four-year degree. Would you agree with that?

Ms Valentine—I do not necessarily agree with it. Part of the issue is to look at the flexibility of delivery of courses and possibly we may not have looked at that. I am not sure why a four-year course would be the way to go. One of the problems that we have experienced within the clinical sector is working with the university semester structure and the requirements that that places on us in terms of the provision of clinical support for students who are coming on a semester-by-semester basis. One of the things that could probably be looked at before we consider going to a four-year course is the semester structure within the universities and other flexible modes of delivery.

Senator GIBBS—You basically want more places within the university structure?

Ms Valentine—Yes.

Ms Collette—I think it is about more clinical time rather than a four-year period. So far we are locked into the academic year which is really short from a clinical point of view. We have students 26 weeks of the year. The other 26 weeks of the year we do not, so it is about that flexibility and more clinical time. It is also about exposing students to shiftwork so we would be very supportive of having the students come to us in an employment capacity. Certainly that would need to be worked out, not as an apprenticeship model from the day they first take up nursing, but maybe two years down the track there would be an opportunity for employment so

that these students can see what nursing is about. Some of the people we take in our graduate programs have never worked night duty and never worked shiftwork and it is such a shock to them to come into the work environment and face the realities of nursing.

Senator GIBBS—Senator Crowley was suggesting that, if there was a four-year course, after doing three years the fourth year would be an internship like doctors do within hospitals. That would give the graduates a hands-on approach. Would you agree with that?

Ms Collette—Certainly.

Ms Valentine—That is a possibility but one of the barriers concerning that is the lack of national consistency. We are dealing with universities based on their perception of needs educationally and the hospitals are not necessarily involved in the development of the curriculum models in terms of curriculum development and delivery. Those issues would have to be addressed quite dramatically so that we could look at whether a four-year model would be appropriate with an internship.

Mr Petty—We are broadly supportive of the concept of the four-year degree. We certainly also believe there needs to be close relationships between universities and hospitals. We are broadly supportive of the concept of the clinical school model. Recently we have been working closely with some of our local universities to develop a concept where students would do their first two years theoretical based in a university. In their second two years, they would be based at the hospital and the university would have a clinical school based at the hospital. That two years would be focused on significant clinical experience to achieve a lot of the goals that we have been talking about here in terms of getting to know the hospital, being socialised into the work force and also developing appropriate numbers of clinical hours.

Many of the university students we deal with at the moment, who have three-year degrees, have very limited clinical experience. They often do 600 or 700 hours in total in their total three-year degree. They often come for clinical placements to our hospital for one or two weeks at a time. We feel those clinical experiences are fairly meaningless because they never get really socialised or accepted into the work force and, by the time they begin to get into the pattern of the work, they have left and our staff find it very difficult to make any relationship.

We believe that clinical experiences need to be more like six or eight weeks long. There needs to be some sort of continuity with them as well and they need to be planned and involve our staff. We certainly agree with the concept of the four-year degree. We would also take it further in terms of looking at funding for the development of clinical schools based on campus. There needs to be a closer partnership between the universities and ourselves in the development of the courses.

Senator GIBBS—Is the lack of clinical work a matter of a lack of funding?

Mr Petty—It involves funding, but it is worth understanding at the moment that, when a student undertakes clinical experience from a university and they come to the hospital, the first question is: who is their clinical preceptor on the ward? The universities might, in many cases, employ that clinical preceptor, in which case they often employ someone who does not know our hospital, who we have to orientate to our hospital and who is really bamboozled by what is

going on. They do not get to know our staff and cannot negotiate appropriate clinical experience for that person. At other times, we might provide the clinical preceptor, but often we do not get appropriate warning and our systems are not integrated in terms of planning that. The quality of clinical experience is often directed by the quality of the preceptor, the person who is supporting them in the clinical environment, the quality of the staff in that area and the involvement of the nursing unit manager. It is not just hours; it is quality. We think at the moment that the quality is poor and the hours are inadequate.

Senator GIBBS—There needs to be far more coordination and cooperation between the university and the particular hospital?

Mr Petty—Absolutely.

Senator GIBBS—There is not enough working in together here.

Mr Petty—That is a major element of it. It is worth recognising too that that working in together takes time and staff. At the end of the day, it comes back to funding to some extent as well. It takes time to develop curricula and to participate in them. You also need to have staff, on the hospital side, who have time to have input. In a lot of ways, we are not funded to provide that sort of service. We are funded to provide patient care and, at the end of the day, that is our focus. We have a commitment to teaching and research, but our access to funding streams is very difficult in respect of being able to support adequate input, give people time to work closely with the universities and for us to develop and mentor our staff as preceptors and educators as well. It is an ongoing challenge.

Senator GIBBS—Thank you. You have referred to standardisation in registration. Is registration different in each state?

Mr Petty—At the moment, if you are registered in Victoria and want to go interstate, you have to get registered in each state. We do not have a registration system that allows you to work in any state. If a person is coming from overseas and they want to work in two or three states, they have to get registration in different states.

Senator GIBBS—Who do they register with now?

Mr Petty—The Victorian Nurses Board is the current registration authority.

Senator GIBBS—They basically would have to register with a Commonwealth authority.

Mr Petty—That would be the concept, that we have a national register of nurses and you register once to practice nursing in Australia and preferably in New Zealand as well, because there is a significant interchange of staff.

Senator GIBBS—Is it a different amount of money in each state?

Ms Valentine—Yes, it is. I am registered in two states. I can say that I pay a different registration fee in each of the two states.

CHAIR—Can you tell us the states and the amounts?

Ms Valentine—In New South Wales, I paid $35 to re-register and, in Victoria, it was $55. There is a difference of about $10 to $20 in re-registration fees.

Senator GIBBS—You do that yearly?

Ms Valentine—You do that yearly.

Senator WEST—The Austin and Repatriation Medical Centre is a large hospital. It has 750 beds and is large by international standards. You are talking about a clinical school in the hospital that worked very well for the last two years, or the last year even, that enabled a heavier clinical stream emphasis. I wonder about Latrobe where you have 10 hospitals. How will it work for you? How are we going to make sure that our RNs to be actually have exposure to small rural hospitals? That is also an area where there is a big shortage and where we want to attract them. Are we giving them enough skills in their undergraduate years to let them loose on small solo practice types of hospitals or through small rural hospitals?

Ms Cerasa—Which question would you like me to start with?

Senator WEST—I do not mind.

Ms Cerasa—Perhaps I will start with the last one first. I do not believe that we give them enough skills to let them loose at the end of three years. I reiterate the comments made by the other people at the table about the fourth year and what that would involve. I also like the idea of the two-year clinical school, or changing the way we actually look at the clinical exposure, because in every forum I go to that is the message that comes through: when they finish three years, they come out and are still not ready for the reality of what they are faced with—whether it is metro, rural or a small remote site.

In response to your question about 10 sites, Latrobe Regional Hospital has 10 sites. Nine of our sites are mental health services out in the community. Within the region there are 10 hospitals, of which we are the largest referring hospital. Yes, we could facilitate exposure because we would look at a model of exchange, we would place students in different environments to get exposure, and I think that that is achievable.

Senator WEST—Whilst those that go to the Austin repatriation hospital would be seeing very good tertiary level nursing practice, medical procedures and everything else that happens there, are they being deprived of a good all-round balanced nursing curriculum and nursing experience because they are not seeing life in a smaller institution and the different requirements and experiences that can be offered? You would not want to just leave the nurses at Austin repat for two years, would you?

Mr Petty—No, the concept is that would be their base but they would do placements outside the hospital as well, some of which would be services that we manage as a health service. We also manage small hospitals like the Royal Talbot Rehabilitation Centre and community service providers, and they would do placements in those areas. We would also negotiate with other hospitals for placements as well. Obviously, they would do placements with the District Nursing

Service as well as placements we do not have at the moment. We do not have maternity services so they would go to other areas for those placements, and their staff would come to our hospital for their acute tertiary placements—that already happens. They would not just work in the hospital for those two years; that would be their centre and they would do placements in other areas. A similar model works for our medical students, where they will be based at our clinical school at the hospital. They will also do rural placements and placements at various other sorts of community services, but that is really their base where they are coordinated from.

It would involve integration. The clinical school would not just be at one hospital. It would involve a network, but obviously it would need to be based somewhere. One of the key elements is that those academic staff would be based at the clinical school in the hospital and that would also enable them to maintain their skills and involvement with what is going on. Because once you are based out of a hospital and you have been based at a university for a number of years, there is often very little interaction with the actual clinical staff and what is happening in the practical arena.

Senator WEST—You are going to need nursing homes again, aren't you?

Mr Petty—Certainly. In each state it is different. In Melbourne, we are health services and we have nursing homes as well.

CHAIR—Nursing homes, as in accommodation.

Senator WEST—No, I mean nurses' homes, as accommodation. If you are going to send them from Austin and Repat out to Traralgon or wherever else, they cannot sleep under the bridge; it gets a bit chilly at night.

Mr Petty—We already have a consortium with a number of hospitals and we also work with Bairnsdale. We offer rotations for staff and we organise accommodation for staff that are moving between different areas, so that already happens.

CHAIR—What sort of accommodation?

Mr Petty—It varies a bit in different areas. Some of the rural hospitals do offer accommodation for their staff—

CHAIR—But what sort? A house down the road? A bed in the hospital?

Mr Petty—It varies between all of those. Some hospitals own houses, so it can be a house. Some still have nurses' homes that they have turned into flats that are used for both patient and staff accommodation, based on cooking needs.

Senator WEST—What do they put their doctors in when they rotate them through?

Mr Petty—Similar.

Ms Cerasa—Latrobe are a part of the consortium as well and we are providing some units if we get some nurses who exchange. But the medical staff have actually got facilities built for them.

Senator WEST—Better than the nurses' ones would be, though.

Ms Cerasa—They are very different. Under the consortium we have initiated the units for the nurses, but they were not available before. We have also looked at houses and units because we have been recruiting from overseas—Canada and New Zealand. To get people established, we have been offering them short-term facilities while they look around and find their own rental properties, or whatever they want to do. But, certainly Latrobe do have facilities for medical staff.

Mrs Kennedy—If you go out to even more remote areas, accommodation is a problem because it is not available. The small hospitals cannot offer accommodation in a lot of cases, and that has been brought home to me with people looking for work and not finding accommodation for the short term. So it does become a problem.

Ms Cerasa—Homestay is one option that one of the hospitals in the consortia is offering. They are asking nurses within the facility to offer a spare room as a boarding arrangement for nurses who are doing this short-term exchange.

CHAIR—Do the doctors do the same?

Ms Cerasa—No.

Mr Petty—It does come back to some extent to funding. When I talk about funding for clinical schools of nursing a lot of it comes back to 'if there was funding available we could offer'. A lot of it is done on a shoestring at the moment. In some cases the medical schools have been established for periods of time and it is accepted and they have built up their funding base and there are different sources of funding for different types of education.

Senator WEST—I am an old RN so some of my vices are about to come out here regarding the treatment that nurses get versus the treatment that doctors get.

Ms Cerasa—I really like the comments that other people have made and I endorse them all. We are a facility that actually have it all except neurosurgery. It is the only thing that we do not do. We do mid and we have obstetrics, so I would be looking at something like an exchange with a place like Mercy to give exposure because what we offer in a rural setting can be quite different from the metro. We have aged care. We have mental health. We do acute. We do rehab. We do the works. So I think that it is quite achievable—as Mark was saying, about different placements at different environments for different exposures—if everybody has got a common focus.

Senator WEST—I was concerned that it could be seen as being a bit elitist if they went to only one hospital and stayed there and got no other experience, that those that had been to, say, the Austin or Royal Melbourne or one of those seen as the top teaching hospitals for medicine might have a snobbish attitude and that those that went to, say, the Latrobe group, where they

would be seeing a very wide range from a fairly high level of acuity of illness through to good community work, would be seen in a less positive light, and I was not wanting that to happen. I am wanting the breadth of experience here.

Ms Valentine—That comes back to some of the issues concerning a national consistency in the delivery and development of undergraduate courses, because the possibilities are that different groups have different ideas about what should go into undergraduate development and how people should actually come out at the end of that time. We are still in a situation whereby we have university courses in the three-year courses but I do not think we have articulated our expectations clearly at a national level of what we expect of students who have completed the three-year degree course. What do we truly expect of them in terms of how they are expected to come into the work place? We talk about graduate years but we do not nationally have a focus about expectation at that level.

Senator WEST—Do you see that lack of focus and the lack of an almost national standard as a problem in the administration of your hospital and in the level of support that is required by new graduates when they hit the wards?

Ms Collette—Certainly in our hospital, no, because we have got a very good support system set up for our graduates.

Ms Valentine—Not in the graduates, no.

Senator WEST—Where do you see it?

Ms Valentine—Postgraduates. Because we are in a situation where we deal with multiple universities for one particular course we find we are dealing with multiple curriculums, multiple demands, multiple considered clinical hours, theoretical hours. They are all different and we are having to look at what our model of care is—particularly in relation to midwifery practice—and to communicate that in the clinical environment to the postgraduate students. We find we are the group communicating what is expected in terms of being a midwife and having the clinical expertise at the completion of the course rather than the universities which I do not think are collectively communicating that. It is a structured course with structured units that fit in with academic years but do not necessarily communicate the clinical expectations of the midwife and the professional standards that they are expected to be able to demonstrate at completion of the course.

Senator WEST—So you could have a situation where you might have employed two people who had just done their postgraduate course in midwifery, and one would be quite competent and capable of handling a normal delivery with minimal supervision, whereas the other would still require supervision. Is that what you are telling me?

Ms Valentine—That is a possibility. We have just come into an employment model of midwifery practice and we are working with four universities, They are quite different, as I have outlined before. As a result of that, we are looking at an evaluation process so that we can look at some of those issues. We are doing a process evaluation this year and next year we will probably try to look at some outcome evaluation, to look at what the differences are, to be better able to identify what those issues are.

Senator WEST—Are you giving feedback to some of the universities?

Ms Valentine—We will be. We have within our process evaluation a plan whereby we will meet with them regularly and give them feedback so that there are no surprises, so that we can change things, talk about what our concerns are and take into account some of their concerns. From our point of view, we really want to be able to articulate the clinical concerns that we have.

Senator WEST—You have all talked about national standards and national registration. What are the problems with the current situation? You have all mentioned it and you want to change it. You had better tell us why you want to change it, how you would change it and what the benefits would be.

Ms Collette—From a national registration point of view, there is a transient population. There are difficulties for individuals when they move from state to state and have to take the time to register in another state. In states like Victoria, once the students finish, it can take them six to eight weeks before they are even registered and able to practise. So the registration, really, from a convenience point of view.

CHAIR—How do you get registered?

Ms Collette—For the first time? The transcripts of results are sent in from the universities, and the completion of the clinical experience. They go to the Nurses Board of Victoria. The board sits and makes the decision about whether you are able to be registered. You pay your money and get registered.

CHAIR—I am a Western Australian nurse. I read that they are paying $260 an hour if I want to go and nurse in Victoria. What do I do: ring up and say I want to be a nurse in Victoria, send my money, then hop on the plane and come over?

Ms Collette—You would probably wait six weeks, until the board meets, to see whether you are able to be registered.

CHAIR—No more than that? Thank you.

Senator WEST—You have to produce evidence that you are registered in WA as well.

Mr Petty—You would have to produce a bit more documentation than that. It would not be enough just to say that you were registered in WA. You would have to produce all your original documentation. Fax is not accepted. You cannot email, you cannot do it online. You would have to fly here first, give us all your documentation, wait for the six or eight weeks and then, assuming you have done everything, you might get registered and then you might be able to start work. We cannot employ you in the interim period, because you are not registered and we have not seen your practising certificate.

Senator WEST—What is happening, say, at Wodonga or Albury, where you have had a rationalisation of the provision of services and where, between Albury and Wodonga, areas of

specialty are being built up in different hospitals so that there is no duplication? How do the staff fare there if they have to move across?

Ms Collette—They would have to be registered in two states. Having come down from Albury—certainly, that was 10 years ago—I had to be registered in both states to be able to practise in Victoria, or in Albury.

Senator WEST—So the community health people, who might be based in one state but following a specialty area—who might be based in Wodonga but have patients in Albury—would have to have two registrations?

Ms Collette—They would need the registration for the organisation that is employing them. If they were employed by Wodonga Hospital, their registration would be a Victorian registration.

Senator WEST—But they are doing community nursing and they have a patient—

Ms Collette—That patient would still come under Wodonga Health Service. That would be my interpretation.

Senator WEST—Maybe when the department comes before us, I will ask them that question.

Mr Petty—Registration standards are one thing, then there are also standards for education. Take division 2 nurses, for example: there are differences in different states, differences in what they can and cannot do and differences in education. To have that standardised as a work force that was moveable between different states and practices would be an important development.

I guess when we are also talking national we find it is very difficult to deal with the Commonwealth if we want to talk to anyone. Who do we talk to in the Commonwealth department of health? With the state we have a nurse policy branch. We have a nurse who leads it who we can talk to and who talks our language. It is a person who we can understand and who we can put ideas to in trying to understand how the system works or how we can influence it. At a Commonwealth level it is very difficult to find who to talk to and deal with and who in the bureaucracy handles or makes the decisions about nursing issues. We have certainly argued very hard that there needs to be a chief nurse nationally as well.

Senator WEST—What would you want to talk to the Commonwealth about?

Mr Petty—Commonwealth funding.

Senator WEST—I have tried and I keep getting the same answer as you do. So tell me why you want to talk to the Commonwealth.

Mr Petty—The Commonwealth funds some of our services to start with. Not all the services that a hospital provides are state funded. There are also Commonwealth services so there are often those issues. There are issues around education. How the system works would be one of

the primary ones. There are issues around recruiting from overseas and these different elements that have a national impact as well.

Ms Collette—There are certainly work force issues across the board. At the moment every state seems to be doing so many of the same things, identifying the shortages of nursing. We are working together in Victoria to try and address some of those issues. I am sure our colleagues in New South Wales and in every other state are doing so. It would be nice to have the unity to work together rather than separately.

Senator WEST—Do you think you have eight organisations reinventing the wheel?

Ms Collette—I would say so.

Mr Petty—I know the state chief nursing officers do get together and try to coordinate elements as well, but it also would be helpful if we had access into the federal bureaucracy and understood what things had been developed and how we could impact in terms of future developments, submissions, funding and ideas and so forth. We have some input into the state but how things are developing at a federal level feels like a bit of a vacuum.

Senator WEST—You have talked about division 2s and division 1s here. Yesterday in Western Australia we kept hearing about ENs and RNs. Can you give some indication of nomenclature here and how that relates to other states? You may not be able give it to me for other states, but can you give me what each one is allowed to do here? Is that too big a task and you would like to take it on notice or should I ask the department?

Mr Petty—You might want to ask the department as well. At a simplified level, division 1 nurses are registered in division 1. They are traditionally the people who have done three-year or four-year degrees. They are registered to provide nursing care whereas division 2 nurses have generally done a 12-month course. Their scope of practice is much more limited. They are not allowed to give medications or look after IVs. They are not allowed to act in lots of areas of advanced practice. There is a whole range of things that they are unable to do in Victoria in terms of their scope of practice. That scope of practice is being reviewed at different points at the moment by different working groups. There is some talk they might be able to give a range of medications if they undertake appropriate educational preparation. That is fairly simplified—

Ms Cerasa—We also have division 3s who are registered psychiatric nurses. They have done a specific program of training for psychiatric nursing only. My understanding is that you cannot do that as such any more. You have to do div 1 or div 2 and then do a postgrad in psychiatric nursing. You cannot do just psychiatric nursing any longer. But we still have those nurses registered so they are still on the nurses board registration and we still view their registration certificates as we do with our div 1s and div 2s.

Senator WEST—Is the fact that you do not have any more div 3s coming on causing problems? Is there a problem in getting access to enough with appropriate additional psychiatric or mental health training?

Ms Cerasa—Absolutely in our service. Our three hot spots for recruitment at the moment that we just cannot get enough nurses to are: mental health, critical care and emergency

departments. They are three specialty areas. My bandwagon is that mental health nursing is a bit like aged care nursing in that it is not attractive nursing. People have all sorts of perceptions about it. It is not glamorous. People have a perception that they do not want to go down the end of the corridor and work with the mad and crazies because it is not very attractive nursing. So it is very hard to recruit div 1s into the postgraduate training. We have a very big problem with recruitment for psychiatric nurses, mental health nurses; the terms are a bit interchangeable at the moment.

Senator WEST—Thank you.

Ms Cerasa—Does Austin have mental health services?

Mr Petty—Yes, we have a large mental health service and we have similar problems. Also, the feeling from mental health nurses is that the current undergraduate curriculum has been cut in terms of mental health. To compress it into three years, you reduce clinical subjects, and in a lot of courses we feel that mental health is being inappropriately downgraded as well. So, when they finish, people have not had enough exposure to or understanding of mental health, they are nervous of the area and then they do not choose to go and work in it. It is likely to become a crisis in the next 10 to 15 years because, when you look at the age profile in a lot of the mental health services in our area, the staff are even older than the general age profile. It is an area of major concern and certainly, internally, we have been trying to beef up our support for graduate nurses with new programs for mental health and the development of more mental health educator positions and better clinical experience for students coming out doing mental health. But it is an area that needs further exploration on its own.

Senator TCHEN—Thank you for your very clear submission. It is easy to read and you refer directly to the terms of reference. That actually raises this series of questions I want to put to you, by way of comments as well as questions. I do not know whether you can answer them directly, but if you feel you need to amplify your submission, please feel free to put it in a written submission.

I think the terms of reference in an inquiry like this tend to focus people's minds on what the inquiry is about—and there is a series of assumptions—and they also limit what you might be looking into. I want to raise these again with you because I think the terms of reference of this inquiry make a series of assumptions which may or may not be correct or totally true. I will go through them very quickly. The first is that there is a shortage of nurses. The second is that there is an agreed meaning of 'shortage'—in other words, when we talk about the shortage of nurses, everybody understands that it means particular aspects of shortage. I am not sure whether that is a true assumption. There is also an assumption that there is a yet to be uncovered solution to this shortage—by that I mean maybe some of the practices already in place—and there may not be one solution. An underlying assumption in the terms of reference which this committee is asked to report on is that this solution lies through training and education. There is also an underlying assumption that the solution has to be provided by government, specifically the Commonwealth government. I think your submissions are quite often limited by these assumptions, so I will ask you to think about whether you agree with these assumptions or not.

Having said all this, can I go to something more specific? Firstly, in the submission by the Austin and Repatriation Medical Centre you refer to division 2 nurses. It is my understanding that there are no longer such people being trained in Victoria any more.

Mr Petty—There are significant numbers of people.

Senator TCHEN—That is the old system of nursing aide, isn't it?

Mr Petty—Yes.

Senator TCHEN—I understood that we put nurses into university to improve not only nurses' education but also the status of nurses. If we now start to emphasise division 2, a sort of inferior nursing profession, are we not reversing the clock?

Mr Petty—At a simplified level, you could look at it like that, but the reality is that there are different levels of work in nursing. It is a complex profession across a range of areas. There is differentiation within nursing in terms of the level of staff required to do specific tasks, and division 2 nurses have an important role to play in direct nursing care and the provision of hands-on care and do not necessarily need to be prepared to take on management or more advanced clinical roles. There is an important role for division 2 nurses in the health system, and division 1 nurses require additional preparation to take on those additional clinical specialisation and managerial roles.

Senator TCHEN—All of you talk about a national registration system. Can the same aim be achieved through portability of registration recognition across the states? If it takes a state board six weeks to register a nurse, a national board would probably take 12 weeks. Can we not achieve the same thing if we have common agreement between the states so that the registrations are portable across the state like doctors' registration?

Ms Collette—You would have to get that agreement first for all the states and that might be the hard thing to achieve.

Senator GIBBS—What is the money that you pay to the states for registration used for? Is it simply a fee of registration? Is it used for a specific purpose?

Ms Collette—I think the whole idea of the nurses board is to protect the community. To do that there has to be an infrastructure for the nurses board to run, so certainly some of the money would go into that protection and paying for those infrastructure costs.

Mr Petty—Part of registration is being able to practise. Part of it is also collecting information on the work force. Different states collect different bits of information and that makes it very difficult. When you ask whether there is a nursing shortage, we would say that there is. But when you look at the data that is available it is very different; states have collected different bits of data and it is very difficult to monitor. My feeling is that there is a significant nursing shortage. If you ask me why this is so, part of it would be education and training, part of it would be that I do not think we are training enough nurses. When you look at the growth in the nursing work force and the number of nurses who are graduating and then project out the dropout rates and people having children, factor in the age of nurses related to the age of retirement and so

forth, to get a standard data set that you can apply all those assumptions to and do modelling with is very difficult to do across Australia. It would also be a standard data collection. Portability would be good, but it would be good if they even just studied it.

CHAIR—We are coming to the end of our time and I am desperate to allow everybody to have sufficient time. Senator Tchen is going to get the call for more questions. Can I just ask you to focus a little and try to resist the temptation to tell us it all. I am so sorry.

Senator TCHEN—I have a question to Ms Valentine or Ms Collette, although the other people touched on this as well. You argue that there should be a review of the awards structure for all nursing positions. I take it that that is across the different types of nursing practices. What are the present inadequacies? If it is too long, put it in writing. It seems to me that part of the problem is that we may have shortage in one practice but no shortage in another.

Ms Valentine—I think that one of the issues there is in terms of education. There is bias in the kinds of courses that are available across the board in education. There are multiple courses in one area and nothing offered in other areas. The nurses find it very difficult sometimes to pursue their speciality because there are no educational courses in that area whereas you might find multiple critical care courses in multiple universities.

Senator TCHEN—Are you a nurse, Mr Petty?

Mr Petty—Yes.

Senator TCHEN—That comes back to the question I asked the previous witness. There seems to be an assumption when we talk about the nursing profession or practitioners that they are only female. In fact, the terms of reference here actually touch on that as well because we talk about providing family-friendly environments. It seems to me that that could be a limiting factor as well. If we limit a profession to one part of the population, that means other people are not interested or not encouraged.

Mr Petty—We would perceive ‘family-friendly’ to mean everyone who belongs to a family, both males and females, and expect that issues around child care and maternity and paternity leave and so forth apply to both sexes. We emphasised in our submission the need for development of the image of nursing to encourage a more balanced representation in the work force.

Senator TCHEN—Thank you, Mr Petty. I just wanted to get that on record.

Senator KNOWLES—I want to ask Mr Crowe a question, because he has been very nice in keeping quiet; however, I think we have to break that cycle. We have now been joined by two others in very specialised areas of nursing: neurology, ICU and ICU coronary care. Could each of you explain some of the difficulties that you have in your specific specialised areas that we should probably be looking at? Mr Crowe, go first. Go on, be a devil.

Mr Crowe—I am in neurosurgery and it is a highly specialised area, so the undergraduates coming into that area and the people in their graduate nurse year find it very difficult to develop competencies and the clinical skills required to work in that area. The lack of clinical support

and education within the hospital system and the development of their skills at an undergraduate level has been a challenge over the past couple of years.

Senator KNOWLES—How do we make it better?

Mr Crowe—More coordinated and lengthier experiences at undergraduate level in hospitals, undertaking a wide range of clinical experiences, would be helpful. Also, we find that the graduate nurses coming in, depending on where they have undertaken their study, are at different levels and require different types of support when they come in, so some type of standardisation of the expectations of a graduate nurse would be helpful.

Senator KNOWLES—Do you think that would then lead to more people wanting to specialise in that area, or just give them a broader knowledge across the board?

Mr Crowe—We do not have difficulty in attracting staff into the specialty area at the moment. For a lot of areas that have postgraduate courses attached to them, though, once the staff undertake that postgraduate education they tend to have an affiliation with that area. The way that the pay structure is set up—once you are specialised you get financial reimbursement for certificate allowances, at the moment—encourages people to stay in those areas. As was mentioned before, some of the other areas that do not have those postgraduate education certificates with them—like general medicine, general surgery, aged care and psychiatry—are probably some of the main areas that have recruitment and retention problems within the hospital. It is very difficult for people to specialise in that area and therefore it is difficult for them to work their way up the career structure because they do not have that postgraduate education to allow them to become clinical nurse specialists or move up the career structure further.

Senator KNOWLES—Also, they are not perceived as the glitzy areas of nursing, are they—mental health and—

Mr Crowe—No. That is a problem.

Senator KNOWLES—That is not what you see on television, is it?

Mr Crowe—No.

Ms Hancock—I have been in my position for eight years and I know from when I first started that we would have 70 to 90 applicants to do the critical care course. That has now decreased to the point that sometimes we are literally putting out advertisements frequently. Since the funding has been that people have to pay to do their courses, I think that they look at it and think of what they have to pay to do a course and then of the remuneration afterwards. Even though there is now the benefit of getting certificate allowance, a nurse—unless they do agency or something—would never expect to earn $100,000 a year like other professions, so what is there at the end of it? People are not putting themselves out as much because they have to pay for their education—

Senator KNOWLES—What is the total cost for them? And what is the benefit at the end?

Ms Hancock—It depends which course they do—graduate diploma or certificate. It is six per cent, I think, for a certificate allowance and eight per cent for a graduate diploma, on their base wage. As to the actual cost per subject, each year we have found there has been a difficulty with the university in that the students were going to have to fully pay for their course, so it could be up to $5,000 or $7,000. At the last minute, they have changed it to HECS funding, so the students pay something like $300 or $400 per subject. As a unit we have initiated a half payment for that to try and encourage people to do the course. But that is our major recruitment tool; any tertiary ICU would be using their course as a recruitment method.

Senator KNOWLES—So there is no other avenue through which people can go into ICU, is there?

Ms Hancock—Particularly in a tertiary ICU. I will not employ—unless it is someone exceptional—a person without a critical care certificate, because I have done critical care nursing now for 22 years and I can tell you that it is a lot different from when I started. The technology now involved means, I think, that you would be opening yourself up to incredible lawsuits, basically—

Senator KNOWLES—I do not understand how you drive the gear.

Ms Hancock—That is one thing. We also have a high dependency unit attached to our intensive care and I am finding that that is a very valuable thing because I employ—and it sounds shocking—untrained RNs in the HDU. They work there for a period of time and we have found that has been very good way of getting people into the ICU course for the next year, plus they get some experience in ICU. We have a course coordinator and a clinical educator and recently, in the last 18 months or so, we started a clinical support shift, which we could expand but, again, there is the matter of finding funding and also people to do it. It is one thing to talk about funding but there is also the issue of actually finding the people to work.

Senator KNOWLES—Who is ‘we’?

Ms Hancock—I meant the unit.

CHAIR—Who is the unit?

Ms Hancock—Me, the director—

CHAIR—Who is funding you?

Ms Hancock—The hospital—I suppose the bottom line is the government.

CHAIR—Hospital funding, not education funding.

Ms Hancock—Not for that sort of thing, but there is for the educator.

Mr Petty—We do not receive any education funding from the Commonwealth.

Ms Hancock—The other factor is that, being critical care, I have a lot of senior staff and they are the ones who are—for want of a better term—poached to go off and fill other positions around the hospital. I have got five people currently out of the unit doing various jobs around the hospital.

Senator KNOWLES—Like what?

Ms Hancock—Liver transplant coordination, education—different positions around the place. Because of the career structure with a very large staff—there are something like 100 plus nursing staff just in ICU—you find that with my position, then five ANUMS and a couple of educators, they have got their clinical nurse specialist grading but, percentage wise, there is no other opportunity for them to go higher. That means that they then, of course, will look for senior positions out in the wider community of the hospital, and that is where I lose people.

Senator KNOWLES—How many beds have you got in your unit?

Ms Hancock—We are funded for 15 ICU and two HDU but we have actually got capacity for about 21 or 22 beds.

CHAIR—Thank you. Mrs Driscoll.

Mrs Driscoll—I run a graduate certificate in intensive cardiac nursing. This basically arose from a clinical need—in coronary care we had a very severe retention and recruitment issue going on and we found, looking at all the universities, that none of the universities offered a course that was appropriate to the coronary care workplace. Cardiac surgery is now on the decrease and interventional cardiology is increasing, and the university system is in that area probably about five to 10 years behind. We found that people coming out of a coronary care course at the university were not actually able to work in a coronary care unit because they did not have the relevant knowledge.

We developed this course on our own and we undertake two critical care subjects with La Trobe University and we run two subjects on site at Austin. In terms of payment, the students pay for two university subjects and we found that that has been successful. The students have basically got a course for half price. However, the problem that we have now is that La Trobe University, which we deal with, is changing all the courses into a graduate diploma and it will be much more expensive than the current graduate certificates and graduate diplomas. We are certainly arguing against it but at this stage we do not have a choice. That is the course that we have to take. The other issue that we have is that in coronary care we have students from my course coming in. We also have students from the intensive care course coming in—

Senator KNOWLES—Are they interchangeable?

Mrs Driscoll—and we also have the students from the emergency department coming in. I am sure Jen will agree that with all these students the permanent staff are just about pulling their hair out by the end of the year because it is very rare that they will have a shift with no students. We are also needing a lot more clinical support to help these students get along because, as Mark pointed out earlier, it is the value of the clinical experience that brings these people back

into the hospital system to stay on being employed at Austin. So we are needing more clinical support nurses and more educators in all the critical care areas.

Senator KNOWLES—Last week when we were all sitting in another meeting I happened to read about packing heart attack victims in ice and the research that was being done in Dandenong Hospital and Europe and how successful it has been. What sort of consideration has that been given in your environment?

Mrs Driscoll—A little bit of consideration but not a lot, because the research is not conclusive. Once the research becomes conclusive then it is probably up to the medical staff to take that role on board.

Senator KNOWLES—In the article that I read the person who was undertaking the research in Dandenong Hospital was quoted as saying that it would almost be a sin now, given what they know, not to utilise that technology or form of treatment.

Mr Petty—There were two articles. The one at Dandenong Hospital was medical emergency teams, which we are doing a pilot with as well. I think the cardiac one might have been St Vincents. That comment, I think, was related to the medical emergency teams which run out of the intensive care unit and retrieve patients in the wards who are having difficulties. That has been an exciting initiative.

It is also worth pointing out that people in positions like Andrea’s are funded by the hospitals. They are not funded through education, and it is an ongoing challenge for the hospitals to provide these sorts of courses and educators. The universities tell us they have no funding to provide clinical support for any of their post basic courses. The hospitals have to fund all that and at the end of the day that detracts from the services we can provide.

Senator KNOWLES—Yesterday I was asking a number of people about the technology of retractable needles and so forth. I am reading here that the Austin and Repat have gone to safe equipment to avoid needle-stick injuries. Well done is all I can say. Where is that funding coming from? That is obviously coming from the state government as well. Is that right?

Mr Petty—Again, the hospital has to prioritise the funding that it receives and we have diverted funding from other sources of the hospital to fund that program so at the end of the day we do not get any more funding or less funding for it.

Senator KNOWLES—It has got to come from somewhere else.

Mr Petty—At the end of the day it comes from other programs, so there will be other programs in the hospital that will be cut to fund that program because we see that as a greater priority. Everything comes at a cost.

Senator WEST—How is it working in the wards—the three clinicians?

Ms Hancock—It is only just being rolled out now. The education is happening at the moment.

Senator WEST—So you cannot tell us how effective it has been or how much extra time it takes.

Ms Hancock—I am on the product evaluation committee. It has been in the process for 18 months or more that we have been looking at different products around town, et cetera. One of the nurse unit managers, recovery actually ran the project and there has been a lot of investigation going. It is a case of a culture change and people will get used to using it, but with the risk of needle-stick injuries it has been a great initiative.

Senator KNOWLES—One of the things that has been talked about already is the question of the four-year course. If you have already answered my question earlier in reply to Senator Gibbs, just say so, and I will read it in *Hansard*. I was distracted and reading something else. Yesterday, we were told that a lot of the training is done basically over a six-month period in a 12-month year. When there is a lack of clinical training, is there anything to prohibit a change in the direction of having some of that clinical training within the other six months and therefore not necessarily requiring a four-year course?

Mr Crowe—The thing you also have to keep in mind is that the undergraduate nursing course has one of the highest contact hours for students. Most university students have to do other types of work to actually support themselves financially. A lot of that work is often done in their holidays, doing whatever they do. A lot of them are doing 40 contact hours a week at the university plus they have to do their rotations on top of that. It might be financially difficult for those undergraduate students to support themselves through the course, if their contact hours remained the same throughout the whole year.

Ms Collette—I think there are two issues there. One is whether they need additional contact hours or how those contact hours are actually done. On the issue of how they are done, I believe they could be spread out over the 12-month period and they would still have the opportunity to work and earn money as well. What we were talking about was putting in additional clinical time over a 12-month period rather than a six-month period with a view to the possibility of employment at some stage.

Mrs Driscoll—There is another avenue. In the three years of the undergraduate training, if at the end of the first year they were able to become enrolled as a division 2 nurse, they could then support themselves during the other two years and also work in the hospital environment—

Senator KNOWLES—And get the exposure at the same time?

Mrs Driscoll—Yes.

Ms Hancock—Which used to happen.

Senator KNOWLES—That is a good idea.

CHAIR—And we will ask off the record at some stage, or even on the record: how does that differ from the old apprenticeship scheme? I do not want to be totally bloody-minded. I was talking outside, and I want to follow up the question from Senator Knowles, which somebody else raised with me. The problem is that nurses are students at university. They are supporting

themselves by getting money during the vacation and so on. Has any thought been given to them being paid to work as nurses in the vacation time, when they could actually be getting clinical experience? A clear distinction could be made: if they are being paid to work it does not mean that they are not also students and eligible for proper supervision to ensure that they are learning before they are working.

Ms Cerasa—The Monash Medical Centre currently has a pilot program where they are doing exactly that—they are employing students that have reached halfway through their second year of their undergraduate course—and they are about to write up their first six-month evaluation of that pilot. From a rural setting, we are particularly interested to see how that pilot goes, because it offers employment opportunities for students. It gives them that valuable clinical exposure and, if I can be really blunt about it, it looks at our employment issues of where to find staff, to staff our rosters.

CHAIR—Thank you for that. I have about 10 questions and I will try and work out which ones should go on notice. Are any of you recruiting overseas?

Ms Collette—Yes, we are certainly recruiting overseas.

CHAIR—Are you talking to each other or doing it separately?

Ms Collette—Separately.

CHAIR—Where are you getting your nurses from?

Ms Collette—Ours are from England.

Mrs Kennedy—New Zealand, Canada, England.

Mr Petty—A range of countries, similarly, and also South Africa.

CHAIR—Are there any Filipino nurses?

Mr Petty—A few.

CHAIR—Are there any South African nurses?

Mr Petty—Yes.

CHAIR—From where?

Mr Petty—Mainly from Johannesburg and some of the other major cities.

CHAIR—Would it help if the government, state or federal, were doing the recruiting of nursing so that there was a more coordinated campaign? Do you all wish to continue to be able to spend money getting advertisements and interviewing people?

Mr Petty—If it were coordinated that would be a good idea.

CHAIR—Says you, but the others are not so sure? Thank you, Mr Petty.

Ms Valentine—I think it would be about the coordination. If it was coordinated appropriately I think it would be a really good idea.

Ms Hancock—If they could expedite the registration too it would be good. I have employed several people from overseas. One chap took eight months to get his registration approved through the board.

CHAIR—Why?

Ms Hancock—Apparently that can be the norm. It is supposed to be eight to 12 weeks for an overseas applicant but this particular fellow needed another bit of paper et cetera, and it seems to be a little bit ad hoc at times. I have heard around town from other unit managers that that is not uncommon.

Mrs Kennedy—I understand that the Department of Education, Employment and Training in Victoria is starting to look at that and they have a web site with people and their qualifications from overseas. You can actually deal through them to be able to then interview them and they will assist you to go through the processes of immigration. That is fairly early on but we have used them.

CHAIR—Would you rather get people from overseas or improve the education and retention in Australia?

Ms Collette—I think the retention has been an issue that we have not actually touched on here at all. This morning we have spoken about financial solutions around education but the retention of nursing staff is really important. We have just been involved in a study of nurses in our hospital. What has come back is that 50 per cent of the nursing staff are at threat of leaving nursing and 50 per cent of the nursing staff are also at threat of leaving our own organisation. It is not saying that they are going to but they are thinking about it. The issue is about organisational culture. If people are in a culture where they really like coming to work, where it is a great place to be and where there is great trust in management and good communication, people are happy in their work environment and are more likely to stay. I really think that hospitals have to take a lot of responsibility themselves. It should not be about asking for money and getting funded, but really looking at what is important to nursing staff in your own organisation and how you can actually retain that nursing staff.

CHAIR—Have you had any success?

Ms Collette—We have, actually. We have a big project on the go and we have identified what the six key issues are about retention for our nursing staff. We have a project set up whereby the nursing staff themselves are coming up with solutions, so it is not driven by management, it is actually driven by the nursing staff. Some of the things coming out of that are certainly not high cost, but things that are really trying to meet the needs of the—

CHAIR—For example?

Ms Collette—Car parking is a really big issue for us, as is reward and recognition. We have practice issues, such as rostering practices and flexibility of staff. There are six key ones.

CHAIR—If you could give us a piece of paper about that, that would be very helpful. I think we have had national registration particularly canvassed. Are the registration bodies the people to whom appeal is made for a nurse to be struck off?

Ms Collette—Is there a registration licence?

Mr Petty—Yes.

CHAIR—The registration people do strike them off, okay. Who actually puts a case that nurse X be struck off?

Ms Collette—That can happen in many different ways. It can be from the consumer or the organisation.

Ms Valentine—It can be a consumer.

Mrs Driscoll—It could be peers from the Coroner's Court.

CHAIR—So we perhaps should ask the registration people about that. National registration seems to be something you approve. Would you approve a national curriculum?

Ms Valentine—I have worked for many years in nursing education in a variety of contexts in the tertiary sector as well as everywhere else. If we had maybe a national curriculum it might give us some consistency. In terms of undergraduates, there are all sorts of different ideas. I think you need national curriculums to be considered in terms of other postgraduate courses as well, because there are all sorts of ideas in all sorts of institutions about what people are required to have. I know from critical care experience that there are a variety of different outcomes in terms of critical care courses. Maybe a national way would be a way to go.

CHAIR—Latrobe suggested that we needed strong leadership. In a word, what do you mean by that—a national nurse or a chief nurse?

Ms Cerasa—We said it in our submission. The answers to those questions are yes and yes. I think Victoria is lucky because, as the gentlemen here before said, we have the nurse at policy branch. So, yes, to that at a national level—but also within the profession, the development of leaders, which is what Ms Collette spoke about before in mentors, mentor programs and leadership programs developing our leaders.

CHAIR—I am sorry to press you because we are so far behind time, but it seems to me—this goes to questions Senator Knowles was asking earlier witnesses—that one of the reasons people do not continue to be nurses is that it is a profession that is not held in high esteem. From where

does esteem in the profession come? Is it from a head nurse, from adequate funding from government or from both?

Mrs Driscoll—Adequate clinical support is definitely one area. Another area is praise within their own environment. We have a fair bit of horizontal violence that goes on within nursing.

CHAIR—Yes, we are very pleased that you have mentioned horizontal violence. Please excuse us, but we do not know what horizontal violence is and our minds wax on. We could come up with quite the wrong idea.

Senator KNOWLES—There was a great conversation on the plane last night, I can tell you.

CHAIR—Anyone who guesses the answer that we came up with will get a prize later. Please explain what horizontal violence is.

Mrs Driscoll—It is nurses—

CHAIR—Beating up on other nurses?

Mrs Driscoll—Yes, nurses beating up on other nurses, downgrading each other and not providing enough support when really we should be. As a group, we should be supporting each other rather than downgrading each other.

CHAIR—Some of us thought it might be the patients biting the hand that fed them.

Mr Petty—There certainly is significant growth in violence towards nurses from the public. That is a major issue in hospitals that is continuing to grow.

CHAIR—That is true, but it is not horizontal violence.

Mr Petty—No.

CHAIR—Horizontal violence is actually the peers beating up on their colleagues. Is that large?

Mrs Driscoll—Yes.

Ms Valentine—Yes.

CHAIR—Heavens above!

Senator WEST—They were described yesterday as eating their own young.

Ms Valentine—That is a good description.

Senator KNOWLES—How do we solve that problem?

CHAIR—We take out their teeth.

Senator KNOWLES—That is what I was talking to the previous group about. If it is an identifiable problem that is causing a drop-out from nursing, surely there has to be a solution to it.

Ms Valentine—I think, picking up on Ms Collette's point earlier about organisational responsibility, that we have certainly addressed it at the Mercy Hospital for Women. We have a nurses open forum. We have addressed it openly and we have actually addressed it in terms of organisational culture.

CHAIR—Have you reduced it?

Ms Valentine—We are trying to as part of some of those retention and best practice issues that we are looking at—those sorts of things.

CHAIR—Is horizontal violence actually when a third-year nurse says, 'You are so stupid' to a first-year nurse? Or does it mean actually physically hitting them?

Ms Collette—The latter would be more workplace violence, but your first example definitely is horizontal violence.

CHAIR—So it is putting someone down and it is taking the mickey out of someone et cetera.

Senator KNOWLES—It is harassment.

CHAIR—Latrobe, why does it say in your submission—and I read this in various places—that the industry will do things? Is the nursing group a profession or an industry?

Ms Valentine—I would like to answer that one. I think there is a conflict. We have an award structure where we look very clearly at remuneration in terms of financial remuneration. We have professional standards of practice in which we are required, in terms of registration, to achieve a certain amount of competency. Unfortunately, we do not have articulation between the two. We do not have consistency. I spoke to somebody in the ANF recently about what is a clinical nurse specialist. Basically it is just an individual recognition of what that person has achieved. But there was nothing mentioned about professional standards of practice and there was nothing mentioned about competencies that had been worked on in the profession by professional organisations. We are probably having problems with our award structure, our professional conduct and our professional competency standards.

CHAIR—I appreciate that. We have not got time to stay on that issue, but if any of you wish to put a few lines on paper about that, the committee would be pleased to receive it, although I would have thought that there is a lot of mileage in maintaining your recognition as a profession. My last question is: why are we now talking about, in two, three or possibly four years, producing the all-rounded, all-perfect, all-competent or go-anywhere RN when, at the very same time, the medical profession is actually recognising that, having spent six years, if not eight, to get a doc you then have to do a couple of years intern and then postgraduate study et cetera? I am just confused about waiting for the all-rounded RN coming out versus the old

system of a first year out to get your first certificate, and the second certificate and so on: a recognition that all of it could not be learnt by the emerging RN.

Ms Valentine—I think some of that confusion is coming from the acuity of care that people are coming out into. Have you heard the phrase 'hit the ground running'?

CHAIR—Yes.

Ms Valentine—There is all of that, and I think some of the confusion is coming from the expectation of being able to fit in and fit into a team very quickly—because of the kinds of problems that are occurring in the work area.

CHAIR—Nurses who emerge as RNs are trained to be nurses, not teachers, but they may find themselves very soon preceptoring—a word I am not familiar with and which I hope I have used correctly—other young nurses who have landed on the ward as undergraduates and who may be only a bit younger than they are. Where does the person who takes over that role—or is required to have that role—get the training to be able to teach?

Mrs Driscoll—At Austin, we have hospital based preceptors who have their own workload and patient load as well as having to preceptor a student. As part of the university requirements, they are meant to fill out a performance appraisal, and yet they have no educational background, they find the performance appraisals quite difficult to complete—

CHAIR—Are you saying that they are not being trained to be teachers?

Mrs Driscoll—No, because they are still working as nurses.

Ms Collette—In our organisation, they go through a preceptorship program that is run by the organisation.

CHAIR—Run by the hospital?

Ms Valentine—Yes.

CHAIR—Paid for by the hospital?

Ms Valentine—Yes.

CHAIR—Not funded by the university?

Ms Valentine—No.

CHAIR—Any chance of getting funding from the university?

Ms Valentine—No.

CHAIR—I have other questions, but we have not got time. Thank you very much for your contribution. If there is anything from our questions that you would like to put on paper to us, including things relating to questions from Senator Tchen and others, please do. We would like notes on one piece of paper rather than a thesis. In saying that, I am caring about you writing it as much as about us looking at it. Please keep it short, and thank you very much for appearing today.

[12.23 p.m.]

MOYES, Mrs Belinda, Principal Nurse Adviser/Director, Nurse Policy Branch, Department of Human Services, Victoria

SOLOMON, Mr Shane, Executive Director, Metropolitan Health and Aged Care Services, Department of Human Services, Victoria

CHAIR—Welcome. The committee prefers all evidence to be given in public but, should you wish to give any of your evidence or answers to questions in camera, you may ask to do so and the committee will give consideration to your request. The committee has before it your submission, No. 960. Do you wish to make any alterations to it?

Mr Solomon—No.

CHAIR—We thank you for your patience following our late arrival. Would you like to make an opening statement.

Mr Solomon—First of all, we thank you for the opportunity to appear before the committee, and we welcome the committee's inquiry into an issue that is of fundamental importance to the Department of Human Services and to the Victorian health system. A lot of the focus has been on how to get nurses back into nursing and how to retain nurses. Our view is that we have done a great deal on that front—and we will go over what we have done—but the obvious has to be looked at, and that is that we need to train some more nurses. That is the very simple proposition we have to put.

I will explain very simply why we came to that view. Last year, we were experiencing a severe shortage of both general and specialist nurses. We undertook a significant recruitment campaign. It had two key dimensions to it. One was a million-dollar advertising TV and radio campaign to attract nurses back into the system. The other was $6 million spent on free refresher re-entry courses. We took the view that, if nurses wanted to re-enter, we had to make it easy for them to re-enter, and there was a financial hurdle, which was that refresher and re-entry courses cost them money. So we made those courses free and we also paid the hospitals to conduct those courses.

From the campaign, the outcome over the system was an increase of 2,300 nurses into public hospitals. That is a 10 per cent increase in the space of a year. That is an unprecedented set of achievements, in our view. The hospitals worked very actively to follow up people who rang our call centre. We had 5,000 people contact our call centre. We made sure that every single one of them was followed through and found a place. We also introduced pre-determined nurse patient ratios, which was, I think, the single biggest step towards improving nurses' lives at the ward level. In other words, the issue of workload was addressed. There are a lot of other things that people can mention—car parking, family situations and so forth—but fundamentally, if nurses feel run off their feet, they will not want to be in the profession, and so we took a very large step towards that.

So, of the 2,300 nurses that we recruited, about 1,300 of those went into reducing workload and about 1,000 went into growth. We have now recruited 2,800 nurses into the system. I should put that in context. In previous years, we have had a consistent pattern of about 400 extra nurses per annum coming into the public hospital system. We have a graph in the submission on that.

CHAIR—Can you tell me those figures again? How many went to reducing workload?

Mr Solomon—Initially, 1,300, but I should say that, from subsequent recruitment, 1,650 went to reducing workload.

CHAIR—And the other figure?

Mr Solomon—The other 1,000 went to treating additional patients.

CHAIR—Thank you. Sorry for interrupting.

Mr Solomon—That is fine. That allowed a quantum leap in making the workplace, we think, a more pleasant place. There is an idea that we can get a whole lot of nurses back from other jobs but, because we tried so hard and had so much success, our view is that that was a one-off. Without wishing to waste the committee's time, I will give an example: the person that ran my children's holiday program said, 'I will never go back into nursing. You work too hard and there is too much paperwork.' When I went to re-enrol my children in her program, I found she had actually taken one of our re-entry programs and was back nursing, so I think we harvested extremely well. Our point is that there is not a lot more joy there. About 70 per cent of nurses registered with the nurses board are actually practising. That is a very high proportion for any profession. Nurses do other things, and they retire. They change their work practices over time. Therefore, in order to meet the demand we are confronting, which is about a four per cent growth per annum in patients, we believe that the solution is training additional nurses.

CHAIR—What was your success with retention of those refreshed and refurbished nurses—or is it too early to say?

Mrs Moyes—We have done an audit of approximately 60 per cent of the people we looked at. Of those, 80 per cent were still in the system, in the public sector, working three to four days a week. We will be auditing again.

CHAIR—After one year?

Mrs Moyes—After one year.

CHAIR—You will be auditing again?

Mrs Moyes—We will be auditing again.

CHAIR—Eighty per cent of the 60 per cent you looked at were still in the work force three to four days a week?

Mrs Moyes—They were still in the work force, predominantly in the public sector, three to four days a week.

CHAIR—Thank you. Is that the end of your opening statement?

Mr Solomon—We have one more comment. Our priority at the moment is specialist nurses. That is where we think the Commonwealth education system is not responding adequately. There are too few HECS funded places. The Bennett report found about 200 of the 1,000 specialist nursing places are HECS funded. If you look at it from a nurse's point of view and say, 'Is it worth my while to do a specialist qualification?', the payback for you personally from a full paying course, given qualifications allowance, is about five years. Why would you want to do it? So our very strong view is that the Commonwealth government needs to ensure that universities are training more specialist nurses. It is in specialist areas that we have become too dependent on agency staff, who are extremely expensive for us and do not provide the level of continuity of care that we are looking for. So it comes back to the issue of training some more nurses, particularly specialist nurses.

Senator WEST—If there is a four per cent growth in patients each year, what is the growth rate in new registrations? Are you getting a growth rate?

Mrs Moyes—I do not know whether we are getting a growth rate; I know we saw a 26 per cent increase in our first preferences for nursing for 2002, and the retention rate during the undergraduate degree is increasing. It is the third highest of all courses in Victoria. We had a 30 per cent drop-out rate in the first year following graduation, and that has improved too and been significantly reduced. But I do not know the direct answer to that question.

Senator WEST—If you are getting a four per cent growth in patients needing care each year, what input are you having into work force planning at a national level? There is planning that has to be done at the national level to get the money for the universities: what input are the states able to have into that, to ensure that adequate additional resources are going to the universities to ensure that the growth rates in patient needs are met?

Mr Solomon—Our view is, historically, nil. It has been a free market system, so we are takers of whatever the universities produce. That has changed recently with the Australian Health Ministers Advisory Council establishing the Australian Medical Work force Advisory Council and a group of officers to deal specifically with the work force issue. So I think there is heightened emphasis nationally on it, but the mechanism for us to have some say in how many HECS places are available for specialist nurses is not there.

Senator WEST—Is the national work force group looking at postgraduate qualification nursing needs or are they only looking at undergraduate needs?

Mr Solomon—This is probably a matter for AHMAC directly. I have actually just come from an AHMAC meeting this morning where those priorities were being discussed. But the approach that they are looking to take is to look at workplaces rather than individual professions. So, for instance, they might look at emergency departments and say, 'What is the mix of staff we need?' rather than, 'What number of nurses do we need?' A secretariat is being established to go with AMWAC, which does very specific medical work force plans—for

instance, we know how many neurosurgeons we need to train in Australia. The new secretariat that is being established is supposed to tell us how many nurses are needed, but it is at a very low level at the moment, with only a couple of staff appointed to it, and it seems absurd to us—and this is the issue that we have been pushing through AHMAC—that we have no plans for such an important part of our work force. If you were to say to BHP, 'How much coal do you need to make steel?' they would be able to answer that question. If you ask us how many nurses we need to treat patients, we cannot answer that question.

Senator WEST—Do you know how many nurses you need to treat patients in Victoria?

Mr Solomon—That is a very interesting question.

Senator WEST—If you had your druthers and there was plenty of stock out there to choose from, how many would you want? What sort of break-up would you want?

Mr Solomon—Do you want to have a go at that?

Mrs Moyes—I am not sure I do. I do not have sufficient data. One of the things that we have had is a dearth of data. We are in the process of building our capability to be able to make those estimates. There are other issues, too, around what level of nurse and whether it is a division 2 nurse versus a division 1 or an enrolled nurse. So I am not sure I can answer that either. We just do not have the data to be able to say that at the moment.

Mr Solomon—It would have to be something in the four per cent range, but it is the mix issue that is critical to us. I think one of the things that has happened with our recruitment campaign is that a number of nurses have been attracted out of the aged care system, so there is a sort of flow-on effect. We have succeeded in getting our general needs more or less met, except in the specialist areas. What has not happened is an increase in numbers in the aged care sector. They are the ones who are now saying, 'You've pinched all our nurses.' I do not know whether that is true or not—it is a Commonwealth issue—but, in response to that concern, we have doubled the number of division 2 nurses we are training in Victoria, to try to—

CHAIR—Mr Solomon, if all your nurses left to work in aged care because it was paying better, would that be a Commonwealth or a state issue? I was taken by your comment that you do not know how many nurses are missing from aged care because that is a Commonwealth issue.

Mr Solomon—We do not run aged care.

CHAIR—And you have no idea how many nurses are nursing in aged care in Victoria?

Mr Solomon—No.

Mrs Moyes—We would only have that information for those working in the public sector. You will be aware that there is a quite significant wage disparity between what those people are paid.

CHAIR—I am sorry, Senator West, I am just going back to this dearth of data.

Mr Solomon—One way of getting at it is to ask how many vacancies the hospitals say we have. Those estimates range from 600 to 800.

Senator KNOWLES—Thank you, Senator West, for allowing me to ask this question. Regarding your recommendation that the Commonwealth should increase undergraduate places, if you do not know how many you are missing, how do you know how many places you would ideally need?

Mr Solomon—Our emphasis has been on getting this nationally and that is what we have pushed through AHMAC. We can give you a number. We would like something more than 400 per annum. That is why we went to the 2,500 target last year. We would like many more emergency department nurses and theatre nurses. We would like not to have to recruit from overseas. I am reluctant to pick a number out of the air, but our view is that it is a national responsibility. If we knew that figure right now in Victoria, where would that plug into?

Senator KNOWLES—I would have thought that that information would still have to come from the states. Even if it was coordinated nationally, the federal government would go to the state governments and say, ‘Okay, how many do you need?’

Mr Solomon—In relation to public hospitals they would, but that does not deal with the aged care work force.

Senator KNOWLES—No.

Mrs Moyes—Or the private hospital sector.

Mr Solomon—And that is why we have gone down the track of regarding it as a national responsibility to do work force planning.

CHAIR—Can you ring up the register and ask how many nurses are registered?

Mrs Moyes—We know how many nurses are registered. We are not able to tell you how many are actually working at this point, because the registration process is not in place.

CHAIR—Sorry, Senator West, this is too interesting an area.

Mrs Moyes—The other issue around undergraduate training and what is coming out at the other end is the issue of combined degrees. I do not know whether the deans have mentioned the emergence of combined degrees that take numbers. For example, at one of the universities there is a combined degree for natural therapies and nursing. The product at the end is not necessarily going to be a nurse that is going to go into the system; it will be someone who wants to set up as a practitioner in natural therapies. So at the end there are also some issues around product—that is an awful word—but I think that those are issues that we need to grapple with as well.

CHAIR—Get a better word, I think.

Senator WEST—Product is fine. What are the problems or issues with national registration? I think you heard me ask the question about Wodonga. If I were in Wodonga, and Wodonga and Albury were doing their thing in breaking down barriers and stopping duplication, and maybe there was a specialty area in Wodonga, and they were doing some out patient outreach work, and you had a patient requiring some sort of attention and care in New South Wales, and you were going to send an RN out: would he or she need to be registered in both states or are we overcoming that?

Mrs Moyes—I think the boards are overcoming that sort of thing, trying to get some national competencies. But I do think we would certainly assist with work force flexibility if we had some, and I think they are certainly working towards that with the national council.

Senator WEST—How much do different standards of training and experience vary between states in certain areas, particularly thinking of the enrolled nurse?

Mrs Moyes—There is a significant difference with the enrolled nurse. We have just been looking at expanding our scope of practice to improve our work force issues, and there is significant difference around the states in terms of the division 2 nurse or enrolled nurse. The national council is just at the moment finishing defining some national competencies, but there is significant work to be done to improve that for division 2 nurses or enrolled nurses particularly.

Senator WEST—So they do not have the same sort of reciprocal registration agreements as the RNs do?

Mrs Moyes—Yes, they do, but in some states of Australia enrolled nurses can give injectable drugs while in Victoria they cannot. So there are some issues around practice and whether they want to or can practice.

Senator WEST—That would require some changes of legislation to the drug laws too?

Mrs Moyes—And regulations, yes.

Senator WEST—I will leave it there, so that my other colleagues can get a chance.

Senator KNOWLES—Wherever we go, we seem to be confronted with a bit of grumpiness about pay levels—not that it is a federal issue, but it is an issue that fits into the whole scheme of trying to get people back into the work force—but you do not seem to have incorporated that level of dissatisfaction into your submission. Are they all over the moon and paid so excessively well in Victoria that it does not become an issue?

Mr Solomon—None of us is like that! The answer we would give is that we pay what we can afford to pay. The Victorian government is not going to advocate higher pay.

Senator KNOWLES—Is there a realistic satisfaction or is there still great unhappiness?

Mrs Moyes—The Bennett report is certainly providing evidence that there are a lot of other things that are much more important to nurses. You heard the earlier speakers talk about how they are treated in the workplace. Whilst money has become an issue—and it certainly has been with our agency nurses—there are a whole lot of other things that, if they were addressed, would certainly improve retention. We do know that it could not be that unattractive. There was a significant increase in the numbers of people who put nursing as their first preference at university. This says that it is an attractive career and there are some things going for it.

Mr Solomon—I will point out where it is a Commonwealth issue. Under the Australian health care agreement, half of our funds for public hospitals come from the Commonwealth. We have had multiple disputes about the inflator factor, which fundamentally goes into paying nurses and is the biggest single item. What we get from the Commonwealth is about two per cent growth to cover increases in salaries, wages and other expenses. That is the constraint that we are all under.

Senator KNOWLES—Has there been industrial action in recent times about incomes?

Mr Solomon—It was not primarily about incomes that the ANF came to us; it was about nurse-patient ratios. It was work related. That is a consequence of the shortage of nurses. We have had nurses working harder and seeing more patients, and eventually it blows. They said, ‘No more.’

Senator KNOWLES—You argue for a national nursing body to coordinate the work force planning. Would you care to elaborate as to how you see that working—gathering all that data, putting it together and proposing it to the states.

Mr Solomon—It is a technical task. I think the way that AMWAC does their work force plans, in particular medical specialities, is technically outstanding. We would advocate that a similar job be done on nurses.

Senator KNOWLES—So that could be used as the model?

Mr Solomon—Yes, that is the model. The idea is that the AMWAC secretariat will be collocated with the AHMAC secretariat, which will deal with nurses and other professions. Our view is that the Commonwealth should probably play a much stronger role. For example, in Victoria we have only had a nurse policy branch for two years. Before that, there was no nurse focus in the Victorian department, which is extraordinary. The Commonwealth has rejected approaches by the states for it to set up an equivalent body that could drive nurse work force planning. There is no focus on it in the Commonwealth department.

Senator KNOWLES—You raised the issue of nurse banks in your submission. Would you like to elaborate as to how you would see that working? Is it working anywhere else in Australia? Is it a factor?

Mrs Moyes—Victoria has a historically higher dependence on agency nurses, or nurses wishing to work casually through an agency, than any other state, although I believe there is a trend in other states for agencies to take hold. Agencies offer nurses an opportunity to work casually with flexibility. Nurse bank is really about offering your nurses casual opportunities to

work for your organisation. We are having a significant degree of success with that. It is seen as one option in a range of things that need to be done. It is about offering flexible work in the public sector. That is what people are choosing to do now. They are reducing their hours, and they want to do other things. It is a bank of nurses working casually in an organisation. It may be across a couple of hospitals or a network of several hospitals. There is a better outcome for quality because those nurses are loyal to that organisation and they understand the process and protocol. It is a better outcome for care than having people walk into the organisation, not knowing its policies and protocols. It is also very stressful for nurses who work in an area—whether full-time or part-time—to have people walking in and out from an agency or from somewhere else. These nurses have to orientate those people, get them up to speed and supervise them. This happens quite a bit, and it is a significant stressor. If someone were able to slot into the ward to fill a vacancy or an unplanned absence, it has to be better for those nurses and will improve their working conditions.

Senator KNOWLES—How about the question of being more family-friendly? Your recommendation here is that employers be encouraged to provide flexibility of employment and leave arrangements to enable employees to manage important family, personal or community issues. Has anything actually been done in that area, other than encouraging the employers to do it?

Mrs Moyes—A lot of different organisations have implemented different things. We will be starting to address some of those issues as part of our Bennett report. The Bennett report in Victoria had 86 recommendations—we are through almost three-quarters of them. Part of that involves looking at other options. We have done a child-care study again, and we will be progressing that work during the year. One of the hospitals has implemented a lot of really family-friendly policies at a local level, and that has had significant effect.

Senator KNOWLES—Such as?

Mrs Moyes—It is about just being a bit more responsive concerning shifts and opportunities for work—or perhaps allowing people to come in a bit later and do different things, although that is not the best example. One of the hospitals has a child-care centre on the campus. In fact, I used to work at that hospital, and that kept me going when my children were younger.

Senator KNOWLES—Which hospital?

Mrs Moyes—That was the Austin and Repatriation Medical Centre. It has maintained that creche for a long time. So I think there are things that can be done within the workplace by looking at women and what they want in the workplace, because the work force is still predominantly female.

Senator GIBBS—Earlier on you were talking about the increase in drop-out rates of nurses after graduation—they graduate, they go to a hospital and then they drop out. How long do they stay at a hospital?

Mrs Moyes—Our data is improving significantly now, but there was a 30 per cent drop-out in the first year out of degree—so they have done three years at university and they are in that

graduate year. At a point in that first year, 30 per cent were dropping out. It is directly attributable to the clinical experience and to support within the clinical environment.

Senator GIBBS—But do they actually work at the hospital for a year and then drop out?

Mrs Moyes—No, it will be during that year. They will say, 'Look, I can't do this anymore—I want to go and do something else; this is not what I wanted to do.' I think it is related to first preferences, and our first preference rate. A lot of people who were going into nursing had perhaps wanted to go into other things. We know our first preference rate is now going up. We have got a study under way which looks at the retention of nurses who got their first preference—whether we have improved our retention by taking people who really want to do nursing and whether this is better for us.

Senator GIBBS—Does the government pay hospitals to take graduates?

Mrs Moyes—We provide a subsidy for them to put in support mechanisms, such as mentoring programs. This is given per graduate for a limited number of graduates.

Senator GIBBS—How much is that?

Mrs Moyes—We provide about $11,000 per graduate. Last year we funded 923 graduates.

Senator GIBBS—How many of those last longer than the one year?

Mrs Moyes—Again, it is improving. I do not have numbers for you, but it has improved.

Senator GIBBS—But are they actually dropping out, or is the hospital getting rid of them to take new graduates?

Mrs Moyes—No, they are dropping out. They are saying, 'I don't want to do nursing anymore.'

Senator GIBBS—There seems to be a problem with more experienced nurses in the hospitals because of this graduate thing—they come out, they do a year and they do not stay at the hospital to go further. Is it correct that there are not enough senior nurses compared to the graduate nurses?

Mrs Moyes—No, indeed—there is an ageing work force. We know that the average age for a nurse in Victoria is about 42 or 44. In some ways there is a lot of derision around that. I am not so sure that that is such a bad thing, being someone who is aged 48—I have a bit of a problem with that.

Senator GIBBS—I think that is very young, myself.

Senator KNOWLES—Don't we all!

Mrs Moyes—These people are absolutely critical, and we need these people to be mentoring the people coming through. So there is nothing wrong with that ageing work force. However, these people are not necessarily being replaced. I think that there are issues around the level of back injury and some of the aches and pains that older nurses get in the acute setting. We have addressed that at a state level with specific funding for back injury programs for nurses. We are now starting to see demonstrated outcomes in fewer injuries for nurses. We are improving the workplace in that sense. There is an ageing work force, but we need people with experience in there to be mentoring the people coming up.

Senator GIBBS—Of course. That is what I am trying to establish. Because the younger ones are not coming through—

Mrs Moyes—They are now. We are improving that.

Senator GIBBS—What is the horizontal violence that we are hearing a lot about?

Mrs Moyes—Horizontal violence is essentially bullying.

Senator GIBBS—I know, but do you have some sort of program in place to alleviate this?

Mrs Moyes—I am fairly passionate about this. I think it is about leadership, the culture of nursing, putting the right people in place and giving them the right support to manage people. I think we are locked into a number of ways of doing things. I think it is about freeing things up: looking at leadership in nursing and looking at a different management paradigm. It is not only nursing, although nursing has a big problem. It is related to the work that nurses do. I gave a paper overseas last year about the work that nurses do. Unless they are given an opportunity to debrief and reflect, and get some control over workload, they become somewhat tough. This is a very simplistic view. With that toughness comes a sense of ‘look, you’ve just got to weather this’. The medical profession sees this too. ‘You just have to weather this; you just have to put up with it.’ People today are saying, ‘I don’t actually have to put up with this. I want to be treated with respect, I want to feel valued, and that is not how I am feeling.’

I think it is about leadership, the management paradigm and giving people the opportunity to reflect and think about practice and the tough stuff they have to deal with every day. Nurses deal with really tough stuff. As we have pushed it to the wall in terms of shorter lengths of stay and higher acuity, there is not the opportunity like I had once to debrief with colleagues when we lived in the nurses home together or went off together, because we are all going off to study or to young children at home. Those opportunities are not necessarily there for people to manage that and reflect on their management style and how they actually treat others.

Senator GIBBS—So is the government implementing some courses?

Mrs Moyes—I have been working with directors of nursing. In Victoria, we are tackling leadership this year. With one of the people who was here before, we have started to do some work on scoping: how we might do some work around leadership, get different people with different ways of doing things, and how we are giving younger people an opportunity to see what we do and some of the bigger stuff. There is nothing formal in place, but we are working through it with our nurse leaders in Victoria.

Senator TCHEN—Are you the Chief Nurse?

Mrs Moyes—Yes, I am.

Senator TCHEN—Good, because in a number of submissions nurses have spoken approvingly of the appointment of the Victorian Chief Nurse, and I was wondering who that person was. I am not sure whether this question should be directed to Mr Solomon or to you. In Mr Solomon's opening statement, he referred to various initiatives that the Victorian government has initiated in the nurse recruitment area, particularly in bringing nurses back in to practise. You also said the strategies you have adopted are approaches to meet immediate needs and that such approaches would not be sustainable in the long term. The recommendations are that, to meet the increasing demand, there should be increased training and that output in the education sector needs to be improved. Many of your recommendations refer to the same thing. One of the earlier submissions that we received stated:

The shortage of nurses may be seen as analogous to a leaking bucket. In order to maintain the required level of water in the bucket (RNs in the system) we can: increase the flow, plug some of the holes, accept and work with a lower level, or seek to fill the bucket with something else of a larger molecular weight.

The Victorian government's position, as represented by you, is that the only way to do that is to increase the flow. Is that right?

Mr Solomon—No, it is not. We are saying that we have tried all the other techniques you have just mentioned, but that, at the end of the day, is not going to be enough to account for the fact that we have more demand coming into the system.

Senator WEST—The bucket is getting bigger.

Mr Solomon—Yes, the bucket is getting bigger.

Senator TCHEN—I just wanted to clarify that.

Mr Solomon—If you were talking to us 18 months ago, we would have said, 'Well, first of all, what we're going to do is have a big drive to get people back into the work force.' What we are saying is that we have done that; now what next? We still have people coming through the door and we still need more nurses.

Senator TCHEN—I just wanted to get that clarified because, from reading this and your written submission and also after hearing your verbal submission, I thought that you were suggesting that that was the only way to go.

Mr Solomon—No. And, to reiterate Belinda's point, the Bennett inquiry had 86 recommendations and they were all about retention and recruitment. We have implemented about three-quarters of those recommendations. Without a doubt, there is more that hospitals can do but we are taking the bird's eye view and saying, 'Let's look at the big picture in the system.' If you start adding what you can get from those sorts of initiatives, they are mostly about inter-hospital movement rather than about the system overall. It is why one hospital has an advantage over another because it has a child-care centre. We doubt whether that will

actually change the total number of people in the work force substantially enough to meet four per cent demand growth each year.

Senator TCHEN—Do you believe that the state has any role in the increase in and supply of training for nurses? For example, your first recommendation is that the Commonwealth government should increase undergraduate nurse places.

Mr Solomon—The obvious answer is of course we do. We provide the clinical placements for most of the nurses that are trained, bar the private hospital sector, and we are not walking away from that. In response to concerns that Belinda raised a few years ago that people were leaving in their first year in practice, we introduced a graduate nurse program. It covers $10,000 or $11,000 per nurse per year so that hospitals can employ special mentoring people and establish programs to assist those nurses to stay.

Senator TCHEN—We heard earlier that there seemed to be a very distinct funding allocation going to the education sector or the hospital sector—that is, particular types of training were to be funded from education or funded from the hospital. When asked, the Austin and Repatriation Medical Centre said that a number of their education programs were actually funded by the hospital and not by the university. In Victoria, does the state have any dedicated funding for nurses' training?

Mrs Moyes—No. We commit the training and development grant money for the graduates. There is one other thing that we do fund that is around undergraduate clinical placement. We provide funds on an ongoing basis every year to help nursing students in their undergraduate degree with their clinical placement to facilitate rural nurses coming to the city and city nurses going to the rural area. We have been putting money into that for the last two years. The state hospital system supports the clinical experience of the undergraduate students to a degree.

CHAIR—Does the state also fund the TAFEs?

Mr Solomon—Absolutely.

Mrs Moyes—And 923 division 2 places.

CHAIR—I think that is an important acknowledgment: not all education funding for nursing is Commonwealth through universities.

Senator TCHEN—Yes, that is right.

Mr Solomon—There is something ironic about this. We are responsible for the training of the work force for aged care facilities and the Commonwealth is responsible for the training of the work force for public hospitals. As I mentioned, we double it. We put an extra 923 places into division 2 TAFE training last year. It is fairly difficult to convince a bunch of state government ministers that basically they should be doing something to support a Commonwealth government program, but they did it because they could see aged care had to stay open.

Senator WEST—Did most of the ENs go into aged care?

Mr Solomon—That was basically why we did it. We would like to see some more ENs in public hospitals but, as Belinda mentioned, there is a scope of practice issue in terms of medication administration.

Senator WEST—You would probably like to see more RNs in aged care too.

Mrs Moyes—Yes, we would.

Senator TCHEN—As you described earlier, we have this complicating factor that aged care is a Commonwealth area of responsibility and yet the provision of aged care nursing education is a state responsibility and vice versa for the hospital education. That brings me back to this question of coordination between state and Commonwealth and between states, specifically on the issue of national registration of nurses. There has been the suggestion that there should be a national registration system. It seemed to me that an alternative might be to have an agreement about transportability between state systems.

Mrs Moyes—And there is that in place.

Senator TCHEN—In what situation?

Mrs Moyes—Some of the boards have mutual recognition, so I think that is what they are working towards. The Nursing Council will be able to qualify that, but they are working towards mutual recognition, I think.

Senator TCHEN—Are all states involved or just some states?

Mrs Moyes—Through the council they are all involved. To what degree they are all doing that I am not so sure.

Mr Solomon—I am not sure we would put that issue right up there in solving any of our problems. You are probably aware that the implication of a single system would be a single board. One of the primary roles of the Nurses Registration Board is to investigate complaints against nurses. I am not sure whether a Sydney based or Brisbane based nurses board would be investigating nurses' behaviour in Warrandyte or somewhere.

Senator WEST—They would also have to be investigating nurses' behaviour under state law, wouldn't they?

Mr Solomon—That is the other issue. We do not have a strong view on it, but would it really address any of the issues that are of importance to the system? We say not really.

Senator TCHEN—In that case, if you do have information—and we will put the question to the Australian Nursing Council—or if you can find other information or if you know of further information, perhaps you can give advice to the committee on that. I am looking at your recommendation 15, which is:

Processes are formed—

and I assume you mean that processes should be formed—

whereby State Health Departments and Tertiary Healthcare Providers liaise on a regular basis.

Is that something which you think is being done, or being thought about, or is that the ideal state? Is it a real problem?

Mr Solomon—We cannot speak for the other states, but our arrangements are very ad hoc, very hit-and-miss. Given the importance of what tertiary institutions are doing for us, it needs to be much more formal and required.

Senator TCHEN—Is it something that you can actually initiate, or does it require Commonwealth action?

Mr Solomon—It is something we can initiate, without doubt, and we actually have done that, but we have not formalised it.

CHAIR—I wanted to pick up on that too. You actually talk about formalised structural processes for interaction between universities and the health care sector. My first question is: isn't there one now?

Mrs Moyes—No.

CHAIR—Amazing. And what is there?

Mr Solomon—Some informal discussions.

Mrs Moyes—Some informal discussions and opportunities. Certainly one of the things that I have done in my role is try to bring people together to start getting them thinking about the decisions they make and how that impacts.

CHAIR—Are you new, Ms Moyes?

Mrs Moyes—Fifteen months.

CHAIR—So everyone now knows how to talk to nurses. How do you talk to the university? Who is it?

Mrs Moyes—It is the deans. I liaise with the heads of school on a regular basis. They advise me regularly. I am in touch with at least one of them every week.

CHAIR—I'll bet.

Mrs Moyes—We arrange a series of meetings where they are included in our decision making.

CHAIR—And then what? Make recommendations to your minister?

Mrs Moyes—I am just trying to think of an example.

Mr Solomon—I think what we are doing is lobbying the tertiary institutions to put more places in. I think that is really the nature of the discussions.

CHAIR—You have raised some very important points that are critical for our considerations. First of all is the fuss of Commonwealth-state relations, brilliantly exemplified here where the state trains the nurses for the Commonwealth and has no idea of numbers, and the Commonwealth trains the nurses for the state and is not really terribly interested in numbers either. So that is brilliant. I was just wondering if there was any way in which you could add to that to further muck it up, but please do not let your mind dwell on that. Where do you go? How do you now set up this formal structure and who is it between? You mentioned the Medical Workforce Advisory Council, which I believe is in the Commonwealth department of health.

Mr Solomon—It is actually physically located in the New South Wales Department of Health.

CHAIR—But the secretariat is from the Commonwealth.

Mr Solomon—I am not sure who employs the staff, but it is physically located there. It is funded by AHMAC, the Australian Health Ministers Advisory Council. It is funded by all states and the Commonwealth.

CHAIR—We will not ask how much each of you puts in. If you have a bit of information on that, it would be useful. Does that mean that nobody owns it effectively?

Mr Solomon—The reports come through AHMAC and they are endorsed by AHMAC.

CHAIR—Excellent. My understanding is that that is an excellent way of making sure that nothing much happens. Which minister is kicking it along? Which minister do you go to to ask for weight to the arm to make it happen?

Mr Solomon—I think in relation to the medical work force the primary interest is the Commonwealth's because the number of doctors that are trained determines the number of provider numbers that are given and how much the CMBS expenditure goes out.

CHAIR—If you want to go through or recommend a model like that, would you want a federal minister of health to own information about work force nurse questions?

Mr Solomon—Absolutely.

CHAIR—Therefore, Mrs Moyes, would you speak to the Commonwealth health minister or to your health minister in Victoria to talk to the Commonwealth minister?

Mrs Moyes—To the minister in Victoria.

CHAIR—It is very likely that any day now, since the Queen has left, South Australia might get a government decision. It could be a Labor government, in which case you would have every state and territory government now of the one persuasion. Given that they are, is it likely that you would want to work with all states to have a very strong arm at the next Premiers Conference on this issue?

Mr Solomon—That is what the Australian Medical Workforce Advisory Council is supposed to do. I think the issue is about how to engage the Commonwealth's education sector. It is not an issue of engaging the states or the state health ministers. They all know the critical importance of it and keep telling us we have to put it right at the top of our priority list. One issue is to get the technical work done. To answer Senator West's question of how many extra nurses we need to train, that is a technical piece of work. The second issue is: how do we ensure, given the way universities are funded, that those recommendations are followed through?

CHAIR—This means that you also have to negotiate with two federal departments.

Mr Solomon—That is exactly right.

CHAIR—Would you be recommending how they talk to each other? I know states are not allowed to even suggest things like that to the Commonwealth but it is a problem. Who is responsible for work forces in this country? It is not usually the health department. How are you resolving education and health challenges at the state level and do you have a model that might serve other states or the Commonwealth?

Mr Solomon—I suppose we do not have the same issue because we go to OPETE, which runs our tertiary further education system. We are engaged in industry specific studies that we are consulted on. We have input into them. That is probably part of the model you are looking for nationally.

CHAIR—Who is doing that research for you?

Mr Solomon—It is done by industry boards.

CHAIR—What do you mean by 'industry'?

Mr Solomon—Industry being whether it is hairdressers or, in this case, nurses.

CHAIR—I thought the nurses were a profession.

Mr Solomon—That is not the way that the TAFE system thinks about life. They think in terms of industries.

CHAIR—So you are asking the TAFE to actually do this research?

Mr Solomon—There is a board put together that deals specifically with it. They do a study that asks whether division 2 nurses are in short supply.

CHAIR—I can appreciate your difficulty here. Would you, for instance, be interested in funding a research program by university A in Victoria that has a school of nursing to find out the facts you need to know about nursing, including Commonwealth or state nurses?

Mrs Moyes—DETYA are still in the process of undertaking a large study. I am on the steering committee of that. That is scoping what nurses are in what courses across Australia. So I think there is work already being done that will be most informative when it is out.

CHAIR—We heard yesterday in Western Australia that one of the challenges they have there is that sometimes the nurses who are second year out, I think, not level 2—it is a bit difficult for me to understand which language we are using to refer to what—get to be a level 3 nurse, which is a unit of supervisory role.

Mrs Moyes—A manager type level.

CHAIR—I hate to think of the words that I might use for them like 'sister-in-charge' or something of that sort, but a person who is now up there. As a consequence they no longer have access to—

Senator WEST—They do not get shift penalties because they are working nine to five, Monday to Friday, as opposed to—

CHAIR—They get less money. By being promoted to a senior supervisory position, they get less money. This does not seem sexy.

Mrs Moyes—No, but that has always been the case with nursing. I made those decisions, too. Everybody makes those decisions when they move into that role. You do get rewarded with a different pay scale—

Senator WEST—Nice hours.

Mrs Moyes—and you have nice hours. So there are some compensations either way, if one is moving up.

CHAIR—Very few people take job satisfaction and nice hours to be satisfactory when they go to a higher level of supervision and competence. Do you mean that nurses have been doing it for a thousand years?

Mrs Moyes—We have done it for years. That has been the way that the charge nurse or the sister-in-charge worked Monday to Friday. That is the way it has been; that is the way it is.

CHAIR—So when this is raised as another reason why nurses are leaving the profession, the answer is, 'It has always been like that'?

Mrs Moyes—I have not heard that that is a major reason why people leave nursing. That is foreign to me.

CHAIR—We were given that as a reason yesterday.

Mrs Moyes—That certainly did not come out in the Bennett report in Victoria.

CHAIR—That is interesting.

Senator WEST—You have certificate allowances, don’t you?

Mrs Moyes—Yes, we have reintroduced that, having taken it away—a qualification allowance, which allows for up to a doctorate.

Senator GIBSON—Basically what they were saying in Western Australia was that there was not much point in doing a postgraduate degree or further education because there was no remuneration for it.

Mrs Moyes—I think, too, it is about support when they move. When they are saying they are dropping out from that unit manager role it is about support. We have asked the unit manager—and this is a great source of dissatisfaction to people who go into that role—to be a charge nurse or a unit manager, but we have not often supported them the way we could have. We expect them to do an awful lot more. We expect them to employ, to hire, to fire, to appraise—

CHAIR—To teach.

Mrs Moyes—and to oversee clinical placements. We have really pushed that role—probably in some cases far too much—and those poor people get burnt out.

CHAIR—What is a unit?

Mrs Moyes—That is a charge nurse. They are managing a ward or a unit because it can be a day procedure unit or a theatre. So it is a unit or ward.

CHAIR—As I read your submission, you dealt with some of the problems raised in Western Australia by trying to acknowledge in pay scales the award for further study. Do you know how many nurses are thundering across the Nullarbor from Western Australia to work in Victoria?

Mrs Moyes—I do not have that on me, but our board would be able to tell us that. The board would know who was registering.

CHAIR—Do you know how many nurses are coming across to Victoria because they can get $260 an hour?

Mrs Moyes—It is a big move.

CHAIR—Well, they just fly over for a week.

Mrs Moyes—This is the agency issue. We are in the process of addressing that issue with some of the things we are doing. I have no doubt that there are a lot of nurses who have been flown in by agencies to reap the profits that there are at the moment.

CHAIR—It certainly seems to be a case that argues: if you are being paid $260 an hour, you will come to work.

Mr Solomon—Sure, but we would all go broke if we paid everyone $260 an hour. We would not have a health system.

CHAIR—I appreciate what you are saying. You have to, perhaps, reflect on how virtuous and successful you have been. Other people are telling us that one of the problems in retaining nurses is the insufficient remuneration for postgraduate study.

Mrs Moyes—It is about support to do that study, as well, with scholarships. In Victoria, we have also funded nurses to do postgraduate study in specialty areas.

CHAIR—'We' in that situation meaning?

Mrs Moyes—We have funded 200. I think it was 200 we put out every year—

CHAIR—Who is 'we'?

Mrs Moyes—The Victorian government, the department. We identify the area of shortage and we support nurses to undertake that postgraduate study so they are not left with the load to pay.

CHAIR—Do you get that money under the health care agreements, under the Premiers Conference or under ANTA?

Mr Solomon—We get it out of state budget. It is a pure substitution for the Commonwealth not having sufficient HECS funded places for postgraduate work. On top of our 200, a number of the hospitals use the grant we give them, the graduate year grant, to provide scholarships as well.

CHAIR—On page 13 you say:

> The criteria of registration bodies compounds the problem ...

I have heard that there is one registration body for nurses in Victoria. Why do you have a plural there? What is it referring to?

Mrs Moyes—Is that across Australia? We only have one registration body.

CHAIR—Page 13 says the criteria:

> ... compounds the problems with stipulations surrounding hours of placement or percentage of course hours spent in clinical placement and types of clinical experience required for registration.

Is this in your answer to Senator West on the question on state to state competencies between enrolled nurses and RNs?

Mrs Moyes—And undergraduates; yes, what is required of training courses.

CHAIR—One of the other problems that we have had is that everybody has told us so far that, whatever else, there is no push, no suggestion or even whiff of encouragement to return to the old apprenticeship system for training nurses; however, everyone is falling over backwards to do exactly that but calling it something different. That is not quite true, but there is a large element of truth to that. Maybe, for example, we will take nurses in a full clinical situation for the last two years of a four-year course. I am interested to know how this proceeds. We have talked here about refresher courses—to just concentrate on one small example—and re-education and re-entry.

A lot of people say we should do that by going through universities, that people could come back and do their postgraduate or re-entry study through the universities. As I understand it, there is very high popularity for doing that in the hospital itself or close to the workplace, that it is much more attractive for people to return to nursing if they are going to do their refreshment or re-registration in the clinical setting rather than going through a university. Is that your understanding too?

Mrs Moyes—We run our re-entry programs through the university. But I think it is about tweaking the system and ensuring that the clinical component of it is sufficient. People that are doing that do need the theory, and the theory is not something that is learned necessarily in the hospital. I think it is about tweaking the system and looking at the clinical exposure, which is what that DETYA study is doing. We have also done some work in Victoria. We have gone out to our universities and said: ‘What are people getting at undergraduate level? What is the clinical experience looking like?’ That is the bit of the system you can tweak.

CHAIR—I am sorry that we are way out of time. Therefore, I ask you to take on notice this last question. How many overseas nurses do you want, and where are you getting them from? I understand from previous answers that each institution is busy campaigning and advertising. Could you give me some information on whether the state is interested in taking over that role? No, it is not? Also, do you know how many nurses are coming from overseas and where they are coming from? What are the challenges and problems and what are the costs to the institutions to be advertising, getting people registered and so on? Can you provide some information about that and whether or not the state would take it up and see some efficiencies there? Do you actively recruit for nurses from other states around Australia? A brief answer on notice is all we would expect.

Proceedings suspended from 1.18 p.m. to 2.25 p.m.

SCULLY, Ms Anne-Marie, Professional Officer, Australian Nursing Federation (Victorian Branch)

GUPPY, Ms Denise, Senior Vice-President, Health and Community Services Union

STEPHENS, Mr David William, Assistant State Secretary, Health and Community Services Union

CRAKER, Mrs Maryanne, Secretary/Treasurer, National Enrolled Nurse Association

ORMEROD, Mrs Maggie, Ordinary Committee Member and Outgoing President, National Enrolled Nurse Association

BRYANT, Ms Rosemary Barrington, Chair, National Nursing Organisations

SCHROEDER, Ms Marilyn, Member, National Nursing Organisations

STICKLAND, Ms Elizabeth, Member, National Nursing Organisations

TCHERNOMOROFF, Ms Robin, Member, National Nursing Organisations

GOOLD, Mrs Jeanny, Chair, Victorian Council of Peak Nursing Organisations; and President, Australian College of Nurse Management

CHAIR—I welcome representatives of the Australian Nursing Federation's Victorian Branch, the National Enrolled Nurse Association, the Victorian Council of Peak Nursing Organisations, the National Nursing Organisations and the Health and Community Services Union's Victorian Branch. The committee prefers all evidence to be given in public but should you wish to give your evidence, part of your evidence or answers to specific questions in camera you may ask to do so and the committee would give consideration to your request. The committee has before it your submissions Nos 379, 728, 367, 477 and 967. Do any of you wish to make any alterations to those submissions?

We want to try and give as many witnesses as possible the opportunity to have a public contribution to the inquiry, so we will take something of a panel approach. I will ask each of you to make an opening statement and then field questions from the senators. If you would like to indicate that you would like to contribute to an answer to a question directed one way or the other do let me know and we will try and fit you all in. But brevity of contribution and brevity of answers will assist us.

Ms Scully—The Australian Nursing Federation, Victorian Branch, has put in quite a detailed submission. We would like to make additions to the comments that we have made. We actually had to do a presentation to the national nursing review chaired by Patricia Heath yesterday, so the links between that and some of the comments we now make will be a question for later.

With regard to nurse education and training to meet labour force needs, one of the things that is now quite obvious to us is that, because of the bulk grants for places at universities, there are no silos or partitioning of places for nursing. So nursing, like other places, has to enter the bunfight to get, particularly, nursing places.

The other major issue with regard to funding for the education places for nurses at universities is, as I am sure you are quite well aware by now, that the clinical component of nursing is not funded to the same degree as medicine is. That is because nursing is aligned with arts despite its clinical focus whereas medicine is aligned with the sciences so they in fact do get a higher weighting for that. That needs to be adjusted if we are to deal with the issues with regard to appropriate clinical education for nurses, both divisions 1 and 2, as they are known in Victoria.

An enormous amount of work has been put in in Victoria to address the issues of retention. I am sure you have heard some here today. In the small amount of work that we have done in asking nurses why they have returned to the work force in Victoria and why they are staying particularly the public sector they are saying it is because in the last enterprise bargaining agreement we now have paid study leave, subsidised postgraduate study times and flexible working shifts and arrangements. In fact, what we have done for this female dominated work force is try to, in all ways, make it a work environment where you would choose to stay.

One of the biggest problems we face of course is making a nursing career more family friendly, because it is 24 hours a day, 365 days a year. Being female dominated, we need to deal with issues like child care and maternity leave. It is varied across the spectrum. Some health agencies have tried to put up after-hours and overnight nurseries. In some way we need to look at combining the provision of those services with other domains outside health, such as local schools or something like that, because the hospitals themselves may not have enough staff with children to maintain them.

We would also like to raise the issue of the success of strategies with regard to occupational health and safety here in Victoria, and amongst those is the no-lift policy, which also makes nursing far more attractive. I am not sure if you are aware of the back injuries in nursing, but a back injury can destroy somebody for life. A very simple lift can actually do enough damage to destroy the quality of life for a nurse. Over $6 million has been put into this strategy, and the intent is that nurses should no longer physically lift and that all equipment should be provided by the employer. In some agencies alone, there has been over a nine per cent drop in back injuries to nurses over a period of time. The cost savings in that are quite phenomenal, especially in aged care. We think that that could easily be generated and looked at as a national strategy for improving occupational health and safety.

The second big issue that we are moving on to in Victoria is occupational violence. We have just completed our handbook and our study with regard to occupational violence for nurses, which has been increasing over time quite unusually, we believe, considering the nature of the work that nurses undertake and the lack of protection they get in their environment. I can assure you that workplace violence for nurses is increasing at a rate which means we now have security guards, locked doors and all those sorts of things in the health sector environment. It may be a reflection of society, but that is our next big issue.

Senator KNOWLES—Is that violence predominantly drugs based?

Ms Scully—No. It could be drugs and alcohol or it could be mental health problems. In fact, some of it is not criminal. For example, in residential aged care, for those with dementia and confusion the violence could be against each other and against nurses. It is a very complex thing, if you are dealing with somebody who has marked confusion, who has febrile or convulsive issues in the neurosurgery wards, or those sorts of things.

CHAIR—What percentage is 'horizontal violence', as it has been described to us? We understand that it translates into bullying.

Ms Scully—Yes, bullying.

CHAIR—That is a useful word; we understand what that means. 'Horizontal violence' did leave our minds wandering!

Ms Scully—There has been an enormous amount of work done on why this occurs in nursing. One of the perceptions that I have been left with after reading about it in some of the studies is that there is nowhere else to take it but at each other.

CHAIR—What percentage of violence is it—small or large?

Ms Scully—It depends on the environment. For example, some wards which have very good leadership in their charge nurses actually have a lesser degree of bullying and lateral violence. So it really depends on the environment; it is difficult to say.

CHAIR—We interrupted you, I am sorry. Was that the end of your comments?

Ms Scully—The only thing that we are concerned with with regard to this review is that senators remember a nurse is truly only a nurse if she has patients. As you focus on research and education, the actual final outcome is the nurse at the bedside providing clinical nursing practice to a patient—in residential aged care, mental health or the acute sector. That is the focus. We want a good outcome to produce these nurses.

CHAIR—I ask the National Enrolled Nurse Association to make an opening statement.

Mrs Craker—I will just give you a little bit of background on who we are, because we are a fairly fledgling group in the nursing arena. We are the national voice for enrolled nurses or, as they are known here in Victoria, registered nurse division 2. But for the purpose of this national review we will be called enrolled nurses. We have representation from all the states and territories and meet throughout the year to discuss things at a national level. It had come to light—and this is the reason why that we are the group we are—that decisions were being made and we were not a part of that decision making process.

Enrolled nurses do, on average, a 12-month course, although in Queensland it is an 18-month diploma course; in other states it is equal to a Certificate IV in Health (Nursing). Enrolled nurses are a crucial component of the provision of nursing practice within Australia. Following

on from some of the aspects that my colleague has covered—and we can expand upon those as requested—we are becoming a more and more vital part of the nursing arena, particularly in the light of some of the aspects that are happening in aged care at the moment.

There is a gross inconsistency in the education of enrolled nurses in Australia, and this is something that has been highlighted by the recent aged care review and the report that came out of that. Given some of the things that are concerning enrolled nurses—and these are part of the reason we submitted the submission that we have to your committee—we need to look at the unregulated, unregistered workers who are employed to attend to enrolled nurse duties and, as I said before, the national lack of consistency in enrolled nurse education. That also brings to mind medication as a component that needs to be addressed sooner rather than later. To be able to facilitate some of the things that we have put in our submissions, we need appropriate funding for the delivery of those curriculums, particularly for clinical placements, which is becoming a huge concern for nurses, both those who are currently registered and those who are studying. They need to have appropriate pay and conditions, and part of those conditions should be a safe environment, which my colleague referred to before. Unfortunately, we could give you multiple examples of the reality as far as occupational health and safety is concerned. The occupational health and safety issues also require adequate funding, which they really do not have at this time.

Senator KNOWLES—On the issue of pay, can I just ask you to expand on what you consider to be appropriate.

Mrs Craker—Sorry, in reference to?

Senator KNOWLES—You used the term ‘appropriate pay levels’. What is your definition of ‘appropriate’?

Mrs Craker—Appropriate funding for the education of enrolled nurses, alongside their registered nurse colleagues. Also, it is becoming more and more apparent that unfortunately there are insufficient funds for clinical placements.

CHAIR—You did say ‘appropriate pay’. What do you mean by ‘appropriate pay’? Do you mean more than they are getting now?

Mrs Craker—I am sorry, I do not know that I did say ‘pay’. If I did, it was not what I was referring to, and I apologise.

CHAIR—No, it may well be that I misheard it. Is that all that you would like to say?

Mrs Craker—At this time. My colleague might like to expand on a couple of points.

Mrs Ormerod—I can only pick up on what Maryanne has quite clearly said, that the inconsistencies with the enrolled nurse role across Australia are quite farcical. Today’s current model of education and training has been criticised by the profession itself due to the lack of clinical component in the undergraduate year, particularly for division 1 nurses, but certainly there are concerns for division 2 nurses. It is felt that for all levels of nurses it is an important time of learning and needs to be addressed, and strategies need to be put in place now to ensure

the clinical needs of all undergraduate programs are met. Partnerships, particularly between the tertiary institutions and hospitals, need to be more clearly defined, and also between the universities and the TAFE colleges, which is currently the sector that educates the enrolled nurse.

A decrease in enrolled nurse numbers has been identified. The data is so outdated that it is very difficult to get current data on what the decrease in numbers has been. But the decrease in numbers of enrolled nurses across Australia and the increase in the unregulated, unqualified worker are of concern. As Maryanne said—I checked that she did not say ‘pay’, she said ‘funding’—the increase in funding would greatly address some of these issues. I am not sure if people on this committee are aware of this, but there are concerns in places like Tasmania where they have lists of thousands of prospective enrolled nurses trying to get into education, and there are no placements out there for them. So there is a concern nationally about the inconsistencies, the placements and funding, and these are the main things that NENA would like to see addressed by this committee.

CHAIR—We will move now to the National Nursing Organisations.

Ms Bryant—The National Nursing Organisations are a coalition of nursing speciality organisations. We have been in existence since 1991. I emphasise that we are a coalition: there are 49 organisations. We would like to reiterate some of the points already made, but I will just go through some of the issues contained in our submission that we believe are perhaps the significant issues for today.

The first one is the current nursing shortages in the workplace and the effect of those shortages on the ability of nurses to undertake professional development and also on the retention of nurses in the workplace. We see that as one of the most significant issues. Along with the Australian Nursing Federation and the National Enrolled Nurse Association, we see the issue of adequate funding for clinical placements for undergraduate nurses as critical. Again, our organisation has put in a submission to the National Review of Nursing Education along these lines. The funding issue to enable individuals or student nurses to gain adequate clinical experience to be able to function as employers expect them to function once they are registered and employed in the workplace is a major issue.

Given that we are a specialty nursing organisation we would also like to bring to your attention the issue of specialty nursing practice. In relation to education, one of the issues is the fact that specialty nursing education can be, and is, in many parts of Australia, very expensive. It is not HECS funded, it is full-fee paying, which inhibits the ability of individuals to undertake those courses, which then has a momentous and quite frightening effect on the specialty nursing work force. To some degree that is the underpinning for the current crisis with the employment and use of agency nurses. I could expand on that later if you wish.

We also believe that there is an issue relating to the role and the proliferation of the unregulated worker in health. We believe that the community should receive health care of the highest standard but we are concerned that there are unlicensed health workers with little or no education who are delivering what is, in effect, nursing care. These workers need to be educated to at least certificate III level and be given the opportunity to matriculate into certificate IV and, of course, into registered nurse or undergraduate nursing programs.

The last matter we would like to bring to your attention is that, if we are going to solve the crisis in nursing, nurses need to have adequate pay and working conditions. I am mindful of your question to my colleague about adequate pay. I do not want to put a dollar figure on that, but what we mean by adequate pay is that nurses should be paid as professionals. Many school leavers, looking at what opportunities for professions or educational opportunities to lead to a profession are available to them, will not choose nursing because, while nursing may give them some opportunity for career advancement, in the long run it will not give them opportunity for career advancement—particularly relating to a professional salary—in comparison with other professions, so that is an issue.

Senator KNOWLES—What types of other professions are we talking about?

Ms Bryant—We could take computer programmers, teachers, physiotherapists, graphic designers, medical professionals, lawyers, accountants and so on. So it is very difficult to attract young women—or young people, I should say; I should not leave out our male colleagues—into nursing, which is a very different situation from when I—I am in my 50s—was a young person starting out.

Senator KNOWLES—If it is so unattractive to do nursing, why are there more people applying to go to university than there are spaces available?

Ms Bryant—There are two issues to that question. It may be that there are not enough places. We know the number of university places has diminished in the last five years. I cannot give you the figures off the top of my head, but the number of places—certainly I am aware of the numbers in Victoria—has diminished, so that may be an issue. The second issue occurs once the individuals get through their program. We have in some states a 30 per cent drop-out rate from the profession once they are registered.

Senator KNOWLES—You are talking about people who are not seeing it as a career?

Ms Bryant—Yes.

Senator KNOWLES—We have been given evidence today and yesterday of the number applying being almost double the number of those being able to be taken in. So, if it is so unattractive as a career, why is the number of those applying double the number of those that can be taken?

Ms Bryant—One of the other issues is that, unlike in the past when we had hospital based training, school leavers or university students often see getting into a nursing program as a means to get into another program, so they will transfer out after the first or second year. There is evidence of a wastage, particularly in the first and second years of the programs. In the third year there is very little wastage.

CHAIR—What is the starting salary for a first year out EN?

Mrs Craker—It would be approximately $11 or $12 an hour.

CHAIR—Is it $500 a week? I think I have your figures here, but would ANF like to tell us?

Ms Scully—It is about $24,000.

CHAIR—For a division 2 nurse at pay point 1 the figures say it is $594.70.

Mrs Craker—That is it. But that is not nationally; that is only in Victoria.

Ms Scully—But it is about the equivalent.

CHAIR—It is about $30,000 to start?

Ms Scully—Yes.

CHAIR—Thank you very much. If you can give us the range later, that would be useful. But I think it is important that we get that now.

Ms Bryant—The last thing I would like to say is that we are also of the view that one of the major issues in nursing is the ability of nurses to work as true professionals in a relatively independent manner and to be in control of their working lives. That goes back to the culture that we have within nursing, which is one of the areas that we need to pay attention to. The health sector as a whole does not always view nurses as the valuable resource—and in fact the essential part—of the health system. So that, we believe, is the fundamental thing in this whole debate. Thank you.

CHAIR—We will now go to the Health and Community Services Union

Mr Stephens—HACSU represents the professional and industrial interests of psychiatric nurses in Victoria, and it is on that basis that our submission deals primarily with the issue of undergraduate nurse education as it pertains to psychiatric nursing. Our particular concern is that there is an inadequate and declining number of safe and competent beginning level nurses in mental health, and we attribute that in large part, if not singly, to changes to nurse education from approximately the 1980s onwards. We take issue not with the fact that nurse education moved to tertiary based training, but that nurse education undergraduate training programs lack mental health content. In order to address that deficiency, nurse education undergraduate programs need to be reviewed urgently and existing nurse training programs should evolve to provide psychiatric nurse education training through specific undergraduate psychiatric nurse education programs.

To put it into some sort of context, prior to the 1980s and 1990s, most states in Australia provided for separate psychiatric nurse training where a graduate would do three years training and come out able to practise as a psychiatric nurse in a psychiatric facility. Similar arrangements existed for all other branches of nursing, including general nursing. However, that arrangement has gradually changed to the point where undergraduate training is no longer provided. So what was essentially an arrangement whereby you previously had separate three-year training programs in the different branches of nursing—that is, general nursing and psychiatric nursing—was abolished and replaced with a single comprehensive model of nurse education where the graduate still completed three years but was expected to perform as a competent and safe beginning level practitioner upon graduation. That has failed.

With the move to what is called the comprehensive model, surveys conducted over the last 10 to15 years consistently reveal that, in many instances, the mental health content of the undergraduate programs varies from zero per cent to 17 per cent. In many instances, research has shown that where they say, 'This is a mental health component,' it is, in reality, not one which could truly be referred to as mental health. That leads to the conclusion that the current comprehensive programs are really no more than the former general nurse programs. That has been supported in other research conducted throughout at least New South Wales and Victoria, and we referred to that in our main submission.

As a consequence of that, a postgraduate qualification in mental health is now seen as the basis for developing basic skills and knowledge; it is not to provide for advanced skills and advanced knowledge, as is the case when one does a postgraduate course for anything else. In other words, postgraduate nurse education is now seen as a substitute for what should be provided by undergraduate nurse education. Compounding this, and it was touched on a little earlier by some other speakers, is the insufficient number of undergraduate places available, and that needs to be addressed.

The consequence of all that I have just said is that there is now undeniable if not overwhelming evidence that we have a crisis in the recruitment and retention of psychiatric nurses for mental health in Australia. That has been supported by numerous reports, surveys and research. Indeed, the former Victorian government acknowledged that in 1997 and the current government acknowledged it in 2001. Different departments of health throughout Australia acknowledge it and service providers acknowledge it. Regulatory bodies such as the Nurses Board of Victoria have expressed their concerns about the quality and content of psychiatric nurse education, to the point where the Victorian nurses board is recommending a review of the undergraduate program. The trends are absolutely alarming and startling in the context of work force projections. Currently the average age of a mental health nurse is 44 but, as you would appreciate, in not too many more years we will be without a skilled and qualified mental health nurse work force.

CHAIR—It will take some time, won't it, if the average age is 44? A lot of professions would be extremely encouraged.

Mr Stephens—I guess the problem is that, when you have young graduates at the age of 20 or 21 with little or no exposure to mental health, to make the average of 44 years we are talking about an aged work force that would carry those skills and the training that we provided in previous times. We believe there must be some agreed basic principles and that it is fundamental that we get agreement around those basic principles. These include that it is understood that psychiatric and mental health nursing is a specialty area of nursing. Undergraduate education should prepare graduates as competent and safe beginning level nurses. Postgraduate education should enhance skills, not act as a substitute for providing them. When those basic principles are established we should adopt the following course of action: that specific undergraduate mental health nursing programs should be the models for delivering psychiatric nurse education. Secondly, in undergraduate programs there needs to be a minimum content of psychiatric nursing and clinical exposure to mental health, and there needs to be additional funding made available to increase the number of undergraduate places, which we referred to earlier.

In conclusion, the World Health Organisation has identified mental health as one of the largest health issues affecting us. Indeed, already in Australia we know that one in five of us will be affected by mental health problems at some stage. Mental health is emerging as one of the greatest health challenges in society, including financially, particularly in respect of health budgets, and we know that it is increasing. We must get it right, and we must get it right at the base. That base includes undergraduate nurse education. Unless you get it right at the base, everything else above it just does not fit into place. The title of our submission is ‘Psychiatric nursing—a profession in crisis’. If we are in crisis in 2002, in five years, for example, it will be too late.

To restate our position: the content and the quality of undergraduate nurse education is failing nurses and other mental health practitioners. It is failing the Australian community and, most importantly, it is failing the mentally ill in Australia. There is a recruitment and retention crisis in the quality and quantity of suitably qualified nurses in mental health. That is directly linked to the quality of undergraduate nurse education. Undergraduate nurse education programs need to be reviewed and existing nursing training programs should involve specific undergraduate psychiatric nurse education training.

CHAIR—What percentage of mental health nurses are ENs and what percentage are RNs?

Mr Stephens—It would be 75:25 to registered nurses.

CHAIR—Seventy-five per cent are RNs?

Mr Stephens—Yes.

CHAIR—And 25 per cent are roughly—

Mr Stephens—That is pretty well a ballpark average.

CHAIR—That is within institutions and in the community or do ENs only work in the institutions?

Mr Stephens—‘Institution’ is a bit of an old word, but enrolled nurses will work primarily in the residential services group—institutions. Community based nurses are essentially the registered nurses.

CHAIR—We should ask Ms Goold from the Victorian Council of Peak Nursing Organisations to speak.

Ms Goold—As I said before, the Victorian Council of Peak Nursing Organisations is a group of four of the peak nursing organisations in Victoria—that is the Deans, the ANF and the Royal College. Given that you have already heard from all of those people, obviously a lot of our submission is based around the thoughts and beliefs of those groups. In some way, I represent what we would call the nursing managers and the nursing leaders of the profession in Victoria. Our representation is predominantly directors of nursing, but also senior nurses such as charge nurses, supervisors and clinical specialists.

We have a real concern that the difficulties that face the profession at the moment cause enormous strain, far beyond what should be, on the nursing leaders and nursing managers. There is an enormous amount of burn-out. There is very little support for those people; there are very few mentoring programs. We spend a great deal of our time trying to shore up the care that is provided with a very limited number of caregivers.

We recognise all the difficulties that have already been alluded to both in general nursing and in the specialty areas. We have particular concerns about issues such as curriculum development, numbers of places available, the types of courses that are offered and postgraduate training. And clinical experience is a major concern for us. There are very limited opportunities for clinical experience currently for student nurses, which you probably heard about this morning from the Deans group. The difficulties that creates for managers in health care settings is to provide support for those people when they are in the field, not only to provide support for the students but to provide support for the registered nurses who are supporting the students. Once again, that places an enormous strain on the industry.

In the past there has not been a lot of money around for nursing education support positions. That has been addressed recently in Victoria, but I do not think it is well addressed in other states. So the pressure that exists for nurse leaders and managers, in Victoria particularly that my group is concerned with, is becoming unbearable for some of those people, and they move on. That leaves the people who work in the industry without role models. That leads, obviously, to a decreased satisfaction and increased problems with recruitment and retention.

Otherwise, I think our group would be particularly keen that some of the specialty problems were addressed in areas such as psychiatric and mental illness, maternity, intensive care—the high dependency areas. The area of aged care, as with psychiatry and mental health, is absolutely in a state of crisis at the moment in Victoria.

CHAIR—Could you tell us very quickly, how is each organisation paid? Who pays you? Where do you get your money from?

Ms Bryant—Our organisation is a coalition. We are all member organisations, but we pay nothing to run this organisation. It is jointly run by the Australian Nursing Federation, where the secretariat lies, and the Royal College of Nursing Australia, where I am employed. So we support the organisation, but each organisation pays for its members to attend meetings and so on. We have no other money.

Mrs Ormerod—NENA is a voluntary—

Mrs Craker—It is totally voluntary.

Mrs Ormerod—Maryanne is the non-paid secretariat. It has been totally voluntary since its inception in 1995. It is based on the membership we can get. It is a very nominal fee to be a member of NENA, to give NENA a voice across Australia, and we are totally voluntary in what we do.

CHAIR—What is that nominal fee?

Mrs Craker—A nominal amount of $30 annually.

Ms Goold—The Australian College of Nurse Management membership fee is $250 a year and that is the only source of funding.

Ms Scully—The Australian Nursing Federation in Victoria has 35,000 members now. Our annual membership fee is $380 full time; part time is different. It provides an extensive range of services, both professional and industrial, and professional indemnity insurance plus legal cover.

CHAIR—Do you enjoy any government subsidies?

Mrs Craker—No.

Ms Scully—Is there going to be a recommendation for government subsidies?

CHAIR—Did you enjoy any government subsidies?

Senator GIBBS—No, they never have.

Ms Scully—In the Victorian branch, we work very closely with the government on certain projects—for example, the no lift policy, so we have put in some of our resources to obviously get out there and foster and encourage, and to do whatever we can to get those sorts of programs implemented.

CHAIR—In other words, the admin gets no money but research grants and so on may, indeed, be enjoyed by some or all of you?

Ms Goold—From time to time, VCOPNO has been supported in one-day forums and so forth by state government departmental services.

CHAIR—Senator Tchen, would you like to open the batting?

Senator TCHEN—I have a series of issues—not so much questions—that I want to raise because they relate to your submission. The reason I raise them is that if you have not thought about those issues I would like to give you an opportunity either to amplify your submissions now or, better still, make further written submissions. These issues relate to the terms of reference of this inquiry. It seems to me that in preparing the terms of reference for the sake of brevity we have made a number of assumptions about the inquiry and about the issues that this inquiry is looking into, and because you have responded to the terms of reference you may have been inadvertently focused in a particular direction. So if I raise them again you might like to look at the issues again.

Firstly, it seems to me that the terms of reference make an assumption that there is, in fact, a shortage—that is taken for granted; secondly, there is an assumption about the meaning of what the shortage is; thirdly, there is an assumption that a solution can be uncovered to solve this shortage; fourthly, that the solution, when it is found, is related to further funding for the educa-

tion and training of nurses; and, fifthly, that this solution can only be brought about by government funding, or particularly Commonwealth funding. But when we talk about shortage, it seems to me that there may be different spheres within the nursing profession and the nursing industry that think the shortage may be more acute or less acute. Two different people from different parts of the industry may have different ideas—or perhaps they are looking at different facts—about what a shortage is when they are both talking about shortages. They might be talking about slightly different things, sufficiently different to make their evidence contradictory, or seem to be contradictory.

CHAIR—Senator Tchen, perhaps we can stop there and get a response to that fairly long question.

Ms Scully—I can talk about the shortage of nurses, and in Victoria in particular, because so much work has been done. We had a labour force committee here where it became evident from the Nurses Board of Victoria that there were 70,000 nurses on the register but only 50,000 working, so somewhere out in the deep morass there were 20,000 nurses, approximately, not working as nurses. This in itself is an issue because the question is why? Why on earth when you maintain yourself on the register would you not work as a nurse? Quite clearly that is a very important question; it is the nature of the work itself.

At that time, you would have to say we had been through the implementation of casemix funding, and we lost 4,000 EFT of nursing over three years in this state. That was phenomenal. What we also had alongside that was an increase in the acuity plus a shorter length of stay, which meant fewer nurses were looking after sicker patients for a shorter length of time. As a result of that, nurses started reducing their hours, so even though we had 50,000 working they were not working full time. In fact, unfortunately, the part-time participation rate in the work force is over 50 per cent in nursing so even though we are saying they are all working, they are working part time. What we are trying to do is fill a phenomenal hole with part-time workers. We would prefer it if they were to increase their hours. Let me say that that is at the bedside itself. We believe that nurse-patient ratios, which we have not addressed, have gone some way to ameliorating that and making them understand that they can have some control over their workload, which was another reason they were reducing their hours. The workload was too phenomenal.

There is a shortage, in a sense, in specialist areas. In rural Victoria I can assure you that we have an absolutely desperate need for midwives. We might have a shortage of obstetricians, but we definitely, absolutely—on paper—have a shortage of midwives in rural areas. The question is: why would you go to a rural town now? Why do you go to regional centres? And the answer is that the population in regional centres is decreasing. We only have seven centres now of over 20,000. We have to look at what can support a midwifery unit. Going to aged care, we have quite a shortage of nurses wanting to work in aged care, probably because of the pay and conditions. I am sure you have heard it over and over again, but the pay can be up to 20 per cent behind the public sector. Why on earth would you work there?

I am running through the points that the senator has made. He said that the solution is further funding. We also say that the solution is some money now, but a definite link in these numbers between the AHMAC work force committee and the university funding to actually earmark places for nursing. At the moment it goes into this big bucket where nursing has to fight for

numbers. Somehow, the Commonwealth would serve the Australian community well by using its own AHMAC committee to say that universities in a contractual agreement have to produce, say for Victoria, 3,000 places a year for undergraduate nursing. So, yes, it does need an injection of government funding so that we hit the right level and then hopefully things will settle down.

Ms Bryant—First of all, I think that we need to look at the global situation. I attended, on behalf of my organisation, the Royal College of Nursing Australia, a global nursing work force meeting, which was a joint meeting between the International Council of Nurses and the World Health Organisation, in October last year. I was, unfortunately, the only Australian representative at that meeting. There was a place for a person from the government to represent Australia but the government chose not to send a nurse to that meeting which in fact inhibited our ability to participate in that meeting. From that meeting I can tell you that there is believed to be a global shortage of nurses in most of the developed countries. In the past—and this is causing a problem right now—the shortages had been in one country or another, and therefore there had been migration from one country to another to fill the holes in those other countries. Now there are still an excessive number of nurses in a number of countries, for example in Poland, and some of them wish to migrate.

I can go on about that but I won't labour that point. We believe, as Ms Scully has said, that there is a shortage of nurses wishing to work in nursing. She has mentioned the issue of nurse labour force planning. There is a dearth of information of actual hard figures on nursing in this country and the Australian Institute of Health and Welfare have now begun to look at nursing as a priority and to actually review the way they collect the data. They have undertaken to get the data out to us and to other AHMAC committees—work force committees and so on—in a much more timely fashion. We are always behind: we are working with 1999 figures at the moment so that is an issue.

Senator TCHEN—They are all the questions I have to ask.

Mr Stephens—With respect to the question of what the assumption is of the shortage, we can say that at the end of January this year, as a result of a campaign through last year to start to address the shortages, Victorian mental health service providers provided details of all the vacancies they had in their services as at the end of January. Only three or four agencies have yet to respond, but at that point there were something like 200 vacancies which they had not been able to recruit to. That in itself constitutes something in the order of just under 10 per cent of the total psychiatric nursing work force. So to quantify it we could go so far as to put that figure on it. But, to put it into a greater context, that figure of 200 nurses in Victoria alone matches up against the fact that between 1998 and 2001 only 400 mental health graduates came out across Australia. That is to match and to provide for a work force Australia-wide, while in Victoria alone there is a shortage of 200 nurses. And, in order to quantify it as well, it is fair to say that all one has to do is look at the costs of agency figures on employers or service providers and the amount of money they are forced to spend on engaging agency nurses. It goes to $1 million a week, to the point where service providers and governments are looking desperately at other ways to be able to provide an interim replacement nursing work force.

Senator TCHEN—Mr Stephens, the situation you are describing I am sure occurs in other nursing sectors as well to different degrees. So the question is: how are we going to ensure more

free movement across the nursing sectors that might help to resolve the problem where the pressure is high and the demand is greatest, rather than looking more generally at training more nurses in that particular area because that be may not be a long-term demand?

Ms Goold—Part of that issue may well be funding for postgraduate places. Anne-Marie would know this better than I would, but there probably is not a huge dearth of nurses in Victoria in the general medical and surgical wards of hospitals because the majority of people who work in those wards are first-year or second-year nurses who haven't yet chosen a specialty and haven't moved on. But come a couple of years time, a lot of them will have decided they do not want to be nurses any more and have left the work force altogether. Or they might stay in that particular area because they cannot afford to carry on with postgraduate education, which may be a postgraduate degree, a diploma in mental health or any other of the specialty areas that exist. But if you take people out of those areas that are already covered you are going to create a dearth of nurses in those areas.

From a management perspective, the great difficulty that nurse managers find with the way even the areas that are currently well-staffed function is that they are staffed by junior staff. It places enormous strain on the managers and the senior staff and creates all sorts of difficulties in the quality of the patient care you are providing. I just add—and this is anecdotal, I suppose—that within the members of my group I have got a lot of nurse managers who are directors of nursing in rural Victoria and who have multipurpose sites whereby they provide community inpatient and aged care on one site. And I have directors of nursing who work all day as directors of nursing and then go to bed and then at 11 o'clock have to get up and go back to work because there is no night duty RN to deliver the babies, work in the emergency department, run the wards and look after the aged care patients. That happens on a regular basis. The turnover in aged care management positions in private health care in Victoria is 29 per cent a year—29 per cent of managers in aged care facilities in Victoria in the private sector leave every year because they just cannot stand the strain.

Senator GIBBS—You are talking about aged care and the fact that you do not have enough nurses. But isn't that because they are paid less?

Ms Goold—Absolutely—and they are funded by the Commonwealth government. We agree entirely. The average age of a patient in St Vincents Hospital last year was 72. So nurses who work in acute health are working in aged care. There is no doubt about that. It is not just residential. Currently, the shortage of residential aged care division 1 nurses, registered nurses, in Victoria is due to the fact that some of them are being paid 20 per cent less than their counterparts in acute care in a public hospital or a private hospital.

Senator GIBBS—Should you not be paying them what their award is?

Ms Goold—We are paying them what their award is. Their award is different to the other award. They work under a separate award, an aged care award, which is negotiated on the basis of what those facilities are funded by the Commonwealth government.

Senator GIBBS—Why has the union not pushed to have aged care workers on the same award rate?

Ms Scully—We have pushed across Australia for this issue. We have addressed the former minister Bronwyn Bishop and have now been back to see the new minister for aged care. I can assure you we do not take it lightly. While we say nurses leave aged care in droves, I can tell you there are the most extraordinarily committed nurses out there—it is almost vocational—who have stuck it out with 20 per cent less salary, working with unlicensed workers. They stay there for the reason that they want to do their best for the residents that they have at that time.

The acuity in aged care over the last 10 years is now such that if you work in a nursing home, a high-level facility, you are looking at 45 to 50 per cent of those residents having extraordinary comorbidities requiring very high-tech medical interventions. For the most part we have an average of one division 1 nurse, a registered nurse, to 45 high-care patients. You would not want to try it. It is quite devastating.

Senator GIBBS—No, I would not.

Ms Scully—But the salaries will not come because the Commonwealth will not review the funding for the RCS for those patients. They will not review it. So we are dealing with employers who, for the most part, particularly in the profit sector, just will not pay. We have some not-for-profits which are now paying loadings to keep the staff, but it is the organisations—the Catholics, the Baptists and local councils—who are bearing the cost of paying the difference so that they will keep the staff at that time.

Senator GIBBS—They have not tried to reclassify them in Victoria like they have in Queensland? I work quite closely with the Queensland Nurses Union. We had a problem up there with the owners reclassifying the job, thereby forcing the nurse out of aged care altogether, simply because the wages were not just 20 per cent less but ridiculously low. They have not tried to do that here?

Ms Scully—They have tried in some senses but of course the Nurses Board of Victoria has to intervene, in a sense. It is also in our Health Act that in a nursing home only a division 1 nurse, a registered nurse, can administer medications.

Senator GIBBS—Yes, of course.

Ms Scully—But Victoria no longer has any regulations governing aged care. Under the Kennett government it was totally deregulated. So in hostels you have unlicensed workers administering medication. I was a member of APAC, the Australian Pharmaceutical Advisory Council, for five years and worked very hard to produce what we call the integrated best practice management for administration of medications, and it is a phenomenal worry to have these unlicensed workers administering medications from dose sets. I know a number of doctors who are deeply concerned because these people, with all the best will in the world—and they may be very nurturing women, and for the most part they are—are administering medications. They have no idea what they are for or when they should be withheld, let alone when they should be given. They are crushing them together, putting them in. We have had a number of deaths recently. It is deeply concerning what is happening in aged care. It is just a shame that we do not have bipartisan agreement on residential aged care in Australia. I think that nurses would hold together. We very rarely see politically bipartisan agreements, but if there is one area in which

everybody should work together, Senators, aged care is it—because that is where we are all headed, unless we want to sit on a beach.

Senator KNOWLES—On that issue of deaths: are you saying that they have been directly attributed to unsupervised or inadequately trained people dispensing drugs?

Ms Goold—Yes.

Ms Scully—Yes. Can I give you an example?

Senator KNOWLES—What has happened to those people?

Ms Scully—How can you hold them responsible for negligence when, in fact, they do not understand what they did?

Senator KNOWLES—Precisely. I do not dispute that.

Ms Scully—That is the issue, isn't it? The best example we have—and I am trying to make this anonymous; that would be important, I think—

Senator KNOWLES—Yes, please do.

Ms Scully—I will say this, so that this is not recognisable. An older woman in a hostel went out shopping, fell and got the usual Colles fracture—that is fine. She went off to hospital in an ambulance. They did an arm block and put her arm in plaster. They had given her pethidine at the hospital, and when she got back to hostel in a taxi the unlicensed workers there got her out and assisted her. She had a lot of pain in the arm and it got worse and worse so they rang the GP, who ordered her Morphalgin, which was dispensed by the pharmacists. Then the workers over a series of time followed the exact instructions for these tablets on the bottle and they gave her two four-hourly until she died of morphine toxicity.

Senator KNOWLES—What happened to those workers?

Ms Scully—It nearly destroyed their lives.

Senator KNOWLES—Were they charged?

Ms Scully—Nothing happened.

Senator KNOWLES—Nothing professionally happened?

Ms Scully—No.

Mrs Craker—They are not professionals.

Senator KNOWLES—When I say 'professionally' I am asking if anything happened to their jobs.

Ms Scully—No, nothing happened to them. What could the coroner say? For all the best will in the world, these particular people had absolutely no understanding. In fact, they were following instructions.

CHAIR—What about the people who employed them?

Ms Scully—Nothing happened either.

Senator KNOWLES—So no-one was actually held responsible.

Ms Scully—No.

CHAIR—Do you mean to say that, even in the light of that experience, nothing has changed about the employment of such people in those positions?

Ms Scully—No. It is not mandatory to have any education or training to work in a hostel, a low-care facility.

Senator KNOWLES—So the coroner did not offer any rap over the knuckles or anything?

Ms Scully—I think at that time it was the beginning of the onslaught. So I think he would say something different, and is saying different things now, to what he was a few years ago. But remember that a coroner has extraordinary powers to demand evidence and to have statements but he has no powers to implement or to make governments do something. It is a Victorian coroner who is looking at some of these cases.

Senator KNOWLES—How many similar cases have there been that you know of?

Ms Scully—Off the top of my head, I have been looking at 19 deaths as a result of nurses administering medications.

Senator KNOWLES—Over what period of time?

Ms Scully—A decade, but that is only the division 1s. I would say there would be about five or so with unlicensed workers, because I have excluded them from my study.

Ms Goold—An example that came to me yesterday was of an elderly lady who is legally blind and who lives in a hostel. From time to time she requires morphine mixture, which is a dangerous drug of addiction and cannot be administered by anybody else and has to be locked away. To enable her to stay in the hostel and because there were not any division 1s, registered nurses, on duty after hours, the morphine was put in the drawer and it was suggested that when she required it she should self-administer it.

Senator GIBBS—Wonderful!

Ms Goold—She is totally blind, and that was the policy.

Ms Scully—She is very happy, you will find now!

Ms Goold—Absolutely!

Senator KNOWLES—In more ways than one!

Ms Goold—As it happened, she had required the medication twice and on both times when she had had the mixture there had been a registered nurse in the building who had administered it and she had not required it otherwise. But until yesterday it was still sitting in her drawer—should she require it she was able to take it on her own.

Senator GIBBS—Orally?

Ms Goold—Yes. It was morphine mixture in a bottle. But you have to measure it; you do not just have a swig.

Senator GIBBS—But how would she know?

Ms Goold—Exactly.

Senator KNOWLES—That is the point.

Senator WEST—Apart from it being a breach of the poisons act.

Ms Goold—There was no-one there. The thing that is so ludicrous about it is that, whether you are in favour of division 2 nurses—or SENs, or whatever you like to call them—giving medications or not, there were division 2 nurses in that building but they are not allowed to give out that medication because it is a dangerous drug of addiction. So if someone had been able to assist her to have it, it would have had to have been a totally untrained, unlicensed worker.

Senator GIBBS—What is an SEN?

Ms Goold—It is a new grade: division 2.

Senator KNOWLES—Mrs Craker, do you have something to add to that?

Mrs Craker—They are enrolled nurses. We said earlier that we would call them enrolled nurses; unfortunately, you were not able to be here then.

CHAIR—An SEN is still an EN?

Mrs Craker—An EN, an SEN, a state enrolled nurse, however you want to term it—our level of nurse. I spoke briefly about it earlier when I introduced who we were and where we came into the picture. As I said then, there are gross inconsistencies in the curriculum for enrolled nurses across Australia. At this point the only state that has gone to the next level, to diploma, is Queensland. I am currently on a committee here in Victoria for extending the scope of practice. Because of some of the things we have just been discussing, the first thing on the

agenda is medications, and we are hoping that will be addressed this year. That is only the first step.

As my colleagues have said, there is a shortage. There does need to be funding. I have to wonder how much of the statistics my colleagues have raised has actually captured the enrolled nurse part of the nursing picture, because a lot of time they have not been included. There have been cuts in many states, at various times, for different lengths of time, to our whole education. This is a part of the big picture in which the shortage of nurses has been created and it needs to be addressed, as does a national curriculum for various things, such as the medication component. NENA, the National Enrolled Nurse Association, is adamant that we want a baseline, which we do not have. Every state and territory in this country needs a schedule that is the baseline for administration, with the appropriate education for enrolled nurses.

Senator GIBBS—The national curriculum has been brought up by quite a few of the witnesses. Child care is very concerning, and I also want to touch on psychiatric nursing. Mr Stephens, in your submission you say:

What was previously two separate 3 year programs for general nursing and psychiatric nursing is now one 3 year program designed to prepare graduates to practice in all areas of nursing.

So I take it that people did their three-year degree and then they specialised in psychiatric nursing or whatever. When was that changed, who actually decided to change it and why? Was it cost cutting?

Mr Stephens—In most states it changed throughout the 1980s. In Victoria it changed in 1993. I am not sure why it was changed.

Senator GIBBS—Are these university courses?

Mr Stephens—They are now university courses.

Senator GIBBS—But were they university courses?

Mr Stephens—Primarily. They evolved through the 1980s, going from hospital based training to university based training, and that is fine, to what is called ‘direct entry’. I would like to clarify one point: the previous arrangement was that a person would enter into a field of nursing and say, ‘I would like to be a psychiatric nurse,’ and they would actually go and do a three-year psychiatric nursing course. Another would say, ‘I would like to be a general nurse,’ and they would go off and do a three-year general nursing course. It seems to me that the reasons why it was changed may well have been linked primarily to funding. Up until the change in Victoria, the state government funded the direct entry three-year psychiatric courses. As we know, by not providing it, it transfers to the Commonwealth through the tertiary sector. I can only suggest that that may be the reason.

Senator GIBBS—Do psychiatric nurses get the same amount of pay as regular nurses at the same level?

Mr Stephens—Yes. The pay rates are now identical.

Senator GIBBS—How can you attract people to psychiatric nursing? It seems to me that you are in dire straits.

Ms Guppy—One of the things in some of the research—and I think we have quoted it in some of our papers—is that, by not being exposed to specific mental health content in the undergraduate curriculum, it does not enter people's—males and females—heads to enter psychiatric nursing. We know from students that they are actively discouraged at the university level and, with respect to my general nursing colleagues, that it is 'not a real field of nursing; why would you want to go and work'—and I will leave out the descriptive terms—'with mentally ill people?'

Senator GIBBS—I would say that one in four of us would appreciate it at some time in our life.

Ms Guppy—Absolutely.

Senator GIBBS—You say one in five; all of my readings have said that one in four of us will, at some stage in our life, suffer some form of mental illness, and we need people to help us.

Ms Guppy—Yes, and changes to the nature of the delivery of services mean that developing nurses and the least experienced nurses are placed in the acute units—no longer institutions, as Senator Crowley referred to—in mainstream facilities, so you have the least experienced nurses working with the most disturbed group of clients. Why in the hell would you want to do that?

Senator GIBBS—Exactly.

Ms Guppy—Our commitment is to the public mental health system. All of us here can afford private health insurance but, I can tell you, the majority of clients in public mental health services cannot, and they deserve a skilled work force.

Senator GIBBS—Indeed. Where I live in Queensland, we have what they would term 'asylums'. There were four; there are now three. They are not exactly nice places—

Ms Guppy—No, they are not.

Senator GIBBS—They are very grim.

Mrs Craker—To add to my colleagues' comments, here in Victoria and in most of the states and territories in Australia you could do mental health as a postgraduate course after doing your enrolled nurse program. Again, that was cut—as a cost cutting exercise, it was said to me—yet there are many enrolled nurses who are working in the mental health area with minimal resources for quality education for them to be able to assist these people.

Senator GIBBS—How can we turn this around? How can we start encouraging people to go into psychiatric health care? I notice that there are not too many men.

Mr Stephens—Less than two per cent of graduates in mental health care are men, and that is a relatively recent phenomenon. Up until the change from the education program in the early 1990s that I referred to in my submission, we were looking at something like, in some instances, 50 per cent male, 50 per cent female or, alternatively, 60 per cent female, 40 per cent male. Leaving aside the question of what supports one can offer the other, it is so important in mental health that you have a balance, because you look to provide adequate role models of all forms. Also, in some instances, people are able to identify with one gender more than the other. It is so important that we have a balanced work force.

Ms Guppy—What are the solutions? It is exposure at undergraduate level.

Senator KNOWLES—Who is discouraging them at the level that you were talking about before? You said that there is active discouragement. Who is the crook?

Ms Scully—I think there are a lot of myths around it, in a sense, and a lot of misinformation and misunderstanding. In the education work force for nursing, I would say that there are not enough psychiatrically trained people as part of the comprehensive program, to stop the demonisation or, when questions are raised, the educator may really have no idea. Instead of referring it on or making sure that they employ a psych nurse that, in fact, it is inappropriate responses.

Ms Guppy—I think that is also around the 'casualisation' of the psych nurse educators, who come in for sessions and are not there when the student thinks, 'I might want to do psychiatric nursing—I might go and talk to my lecturer.' They are just not there. What attracted me to psych nursing was that I saw someone with a bit of energy and a bit of spunk, and I thought, 'That's what I want to do.' But we have not got that any more in our universities.

Ms Bryant—As we are representing the specialty nursing organisations, we could say that the scenario being discussed at the moment is repeated in the other specialties. We see the same thing in neo-natal care, particularly, and also in critical care, operating room nursing—my colleague here is from that area—cancer nursing and so on. I alluded earlier to my hospital based training. We were exposed to many of those areas when I was a student nurse. I had four-year training.

Senator WEST—There are not too many of us left with four-year training.

Ms Bryant—No, there are not many of us left. Some of us came from Queensland. We had exposure working in all of those areas. It is now not possible in an undergraduate curriculum to give exposure to all the specialties in nursing because of the time constraints. Many of my colleagues would say—and some of them may wish to comment—that once a person is registered there may be an opportunity for them to work in some of the specialty areas and to go on to be specialists. But there needs to be some sort of encouragement from those in the specialty fields—as role models or whatever—to attract them into the specialties. I certainly do not wish to diminish or criticise the situation in psychiatric nursing. It is indeed critical, as has been stated.

CHAIR—When you say 'role models', is that what you meant by 'spunk'? Are we allowed to ask the gender of this 'spunk' person? I am terribly interested, actually, because if it was a

walking, talking, fantastic guy, it is going to be a little bit difficult to introduce some 'spunk' or good role models into other areas.

Senator KNOWLES—It would be even more exciting to write them in policy!

CHAIR—I take it you are talking about someone who was really keen about psychiatric nursing, who actually talked about it as a great thing to do.

Ms Bryant—Yes, and it was their career.

CHAIR—You raised something interesting; perhaps we can talk about it later—this might go for all of you: if in the past, over three or four years, we could give nurses experience of a whole lot of clinical settings or different sorts of nursing care—through three-month rosters in different areas, for example—why can't we do it now? Mrs Craker, it is your turn.

Mrs Craker—Part of what I was going to say was raised by my colleague, and that was following on from colleagues on this side. We have talked about this amongst ourselves and we think there could be simple strategies. We think there should be an ongoing, accurate advertising campaign to raise the profile—a campaign by nurses with proper resources on an ongoing basis, so that nurses and what they do can be known. I wish I had a dollar for every time I had someone say, in the ward situation, 'I never knew what nurses did until I came here.' That is something that we need to address on an ongoing basis.

CHAIR—I am sorry to interrupt, but Senator West has to leave and I thought we might give her the call for a couple of questions and then come back to Senator Gibbs.

Senator WEST—I wanted to pursue with Ms Bryant—or anybody else here—the issue of specialty nursing practice. I want to ask about the expense of it. We have had put to us, by other witnesses earlier today, that maybe training needs to go to four years. What would be the impact of that? You said that this problem with the lack of specialty nursing areas was underpinning the current crisis and leading to the use of agency nursing. I would like you to expand on those, please, if you can.

Ms Bryant—I represent the national nursing organisations, and we have not articulated a position on the four-year degree. I can give you my personal views. I have been around the debate for many years in my many former lives and certainly, when we transferred nursing education from the hospitals, I was heavily involved in the transfer in both South Australia and Victoria when we transferred—it was at diploma level, as you probably know—into a three-year program. There are many of my colleagues who would say that that was a mistake, that we should have transferred into a four-year degree program. There was not the money to be found at the time. One of the disadvantages of nursing, when we are dealing at a high policy level, is the numbers. We are not talking about podiatrists or physiotherapists or, indeed, even doctors. We are talking about a very large number of individuals, and to increase a program by one year we would have to be very convinced that this was necessary.

I think that the two sides of the coin are that, with a four-year program, you should be able to give more exposure to what we call the specialties or the specialised areas of nursing and to more clinical experience. On the other side of that, I would say, how much is enough? We do

not know what that is. That is the first thing. The second is that—and I was very involved in this debate in South Australia—we transferred nursing education from hospitals, where the student nurses were paid so that they were able to earn money while they were training—in other words, getting an education—into universities where they have to pay and are also not paid. To increase this to a four-year program may place a very large burden on individuals and individuals' ability to undertake nursing. I think that we would need to look at these areas very carefully before we advocated a four-year degree. I personally would not be convinced that the outcome would be worth the pain. If we put funding into a four-year program—across the board I am talking about; we already have a four-year program at La Trobe University, and there are programs of 3½ years in a number of states and territories: in the ACT and WA, for example—we would need to look at the cost-benefit of doing so. So, that is the first thing.

Regarding specialty issues, we used to have nursing specialties with courses for registered nurses in hospitals—some were in community health centres but most were in hospitals. Particularly if we use the example of critical care nursing or even operating room nursing and emergency nursing et cetera, again, they were apprenticeship type courses; in other words, the individuals were paid so they were part of a work force, and they were receiving an education at the same time. By and large, those programs have been put into universities and are at graduate certificate, graduate diploma and masters levels. I would include midwifery, of course; I have not forgotten that, though I looked as if I had.

The issue there is that now, as I said earlier, many of the courses are full-fee paying at specialist level, which means that individuals have to find the fees. In the case of most midwifery programs, the students have to be in the program full time and so they forgo their salary—they have to find the fees and forgo their salary as well. The structure of the nursing award is such that they are then not assured of recouping that investment in education. This is unlike many other professions. For example, if one undertakes a MBA at a cost of, say, $20,000 then that is seen as an investment in the future because of the high salary levels that an individual with an MBA may be able to attain. Nursing is not able to do that, and so that reduces the incentive for individuals to take up specialty nursing. On the other hand, in a number of states in Australia, particularly on the eastern seaboard, critical care nurses, for example, can be paid fairly high salaries through agencies because the marketplace is ruling. As we heard, $1 million a week can be spent on agency nurses.

Senator WEST—Which is a huge amount of money. What recommendations would all of the bodies make to overcome this problem of specialty nursing areas? We have heard about new graduates getting preceptoring and mentoring, but when people are moving into specialty roles and moving up—I think, Ms Goold, you said moving up to unit managers and similar positions— what is in there for preceptoring and mentoring that particular group? That next level up is where we seem to be losing the expertise. We have the new ones coming through, there are plenty of those junior less-experienced nurses, but we are losing that group with the experience and the corporate knowledge that you actually want to keep. What is in there that is going to keep them going?

Ms Bryant—I will just answer first your question about specialty nursing. I think that is very important. There needs to be, on the part of the universities or through the Department of Education, Science and Training, a commitment that there will be funding for specialty programs through HECS, that they will not be full-fee paying. That would at least ameliorate

the situation in the first instance. There may be then, at hospital level or at state level, even scholarships for nurses to undertake those programs. There needs to be some sort of up-front incentive for them to undertake them so that they are not financially disadvantaged; that is the first thing. There are a range of mentor programs in hospitals, universities and so on. I think my colleagues might be able to answer that more specifically that I can.

Ms Goold—There are certainly no mentor programs that I am aware of in Victoria for nurse unit managers. Any mentoring that is done of those people is done by their director of nursing, their educator or somebody who is able to do it for them. In fact, it may come from their other colleagues; a lot of support for nurse unit managers comes from other nurse unit managers, who are struggling themselves with the difficulties that they are encountering. There is a great need, in my opinion, for nurse unit managers and above to actually be trained in business management principles that have nothing to do with nursing.

When anyone asks me what I recommend nurse managers study, I am sad to say that I always recommend they should study an MBA; I never say anything to do with nursing. Partly that is about the recognition of nurses who have MBAs versus the recognition of nurses who have a master of nursing administration—and they are not even close, let me tell you, being one of that latter group. I think that the idea of mentoring anybody within the hospital field or within other facility fields is very limited, not only because there is not a lot of funding for it but also because there are not necessarily the skills or time available to do it, because everybody is so busy doing their job.

CHAIR—Could you take on notice and perhaps provide us with some comments about the old ‘give ‘em a chance at every specialty’ and why that cannot be done? I think that was the tenure of the question.

Ms Bryant—In the undergraduate—

CHAIR—It is the one I asked you earlier to hold and come back to as to how it is. You say it is a matter of time and so on. Maybe it is not fair to grab you as you are leaving.

Ms Bryant—That is all right. Please go on.

CHAIR—The question I asked you to come back to is when you said, ‘When I was a student nurse, we had the opportunity for clinical experience in a number of different kinds of areas because we had the three-month placements and so on.’ Why can’t that be done now?

Ms Bryant—The first thing is that the academic year is 26 weeks.

Ms Scully—On that, can I just say that we have just worked this out.

Senator KNOWLES—What part of the other 26 weeks do we use to do what you are saying?

Ms Scully—It is the academic—

CHAIR—Ms Bryant, if you can wait a moment, Ms Scully wishes to get to Senator West as she is leaving. Ms Scully, you are on.

Ms Scully—I think one of the clear understandings you must have is that the three-year program in the hospitals that so many of us went through went for 138 weeks. The three-year program now, with 27 weeks as an academic year, goes for only 81 weeks. So we lost nearly 50 weeks from the program in one fell swoop.

Senator WEST—That is the point that I am trying to raise.

Ms Scully—Why can't part of the other 26 weeks be used in the hospitals? Why can't the universities change the way they educate to fit a very different working environment? You always look to the nurses and the hospitals to change—we cannot. Nursing is 24 hours a day, 365 days of the year; yet we are confined to a 27-week window in any given year in a program.

Senator KNOWLES—I am not trying to shift the responsibility to the hospitals or the nurses. I am asking whether it is a practical option for us to look at the universities utilising part of the other 26 weeks.

Ms Scully—Yes.

Ms Goold—Could I ask if that was discussed this morning?

CHAIR—Yes, it was.

Ms Goold—It is certainly something that was discussed at length at a two-day forum last year for cognising. The response we got from the universities was not positive.

Senator KNOWLES—It was also a bit of a guarded response, too, in so much as one witness said that would eat into the time that a nurse undergraduate has to earn a living.

Ms Scully—That is a point.

Ms Goold—Except that university undergraduate nursing courses are like a lot of other undergraduate university courses—they do not work full time. There are a number of days in the week in some of those programs when the university student nurse is not—

CHAIR—I am going to have to stop now. Ms Bryant, thank you very much. We do not wish you to miss your train, plane or next appointment. If there is anything further you would like to put on paper for us, feel free.

Ms Bryant—Thank you very much.

Senator KNOWLES—I do not want those involved in general nursing to take this the wrong way, but at the moment I want to concentrate more on aged care and mental health. I think that these are areas which have been discussed earlier and are clearly missing out. Are you able to tell me how we go about solving the problem? You have come up with some of the problems,

where nursing is being undermined in the tertiary institutions. I do not know how you solve the problem of personnel, but there have to be ways that we can solve the problem of that under supply in aged care and mental health. There is also the attitude that young people might have to helping oldies or the mentally ill.

Ms Goold—I know it is not my field, but can I just make a comment about mental health. One of the things that our group feels and certainly that I personally feel about mental health is that when student nurses and then graduate nurses are working in the acute sector, for instance when they first come out—and we are saying that one in four people in the community have mental health problems; that means that a lot of people in public hospitals and private hospitals have mental health problems—there is generally, in my experience, a dearth of psychiatric nursing specialists to support general nurses and doctors in acute settings. So when a general nurse sees a psychiatric issue it is usually not well handled. That leaves them with a very poor perception of mental health issues. It certainly does not encourage you to go on and work in a mental health area. You do not actually see a good solution to a situation very often.

Some of the psychiatric assessment teams that have now been placed in acute settings such as casualty departments and so forth are an enormous boon to nurses who work in acute facilities. I say that from my experience. I was an after-hours coordinator at the Alfred for three years and at that time we had no psychiatric support team. We had a psychiatric unit. The two nurses in it, who I used to have to go and relieve so they could go and do something with psychiatric patients in casualty, had horror stories like an orderly who dropped dead of a heart attack while he was chasing a drug addict through the hospital—terrible stuff! If you are a graduate nurse seeing that sort of thing you do not want to go and work in mental health. You do not see the good sides of mental health. I guess I also speak from experience because I did psych nursing a long time ago. I think that we need to do something about getting more psychiatric specialists —where we find them I am not sure—into the acute settings to support those people in their early days so that they are actually aware that there are situations that can be assisted and that there is work that psychiatric nurses do that is highly specialised and effective.

Senator KNOWLES—Correct me if I am wrong, but aren't you basically talking about people who are already in the hospitals by that stage, as opposed to the undergraduate—

Ms Goold—Yes, indeed. Both really, but certainly predominantly postgraduate people who would then may be encouraged to do postgraduate psychiatric training.

Senator KNOWLES—But also the problem is similar, I would imagine, in aged care, where people think, 'I don't want to look after incontinent Alzheimer old people.' And that is not the total role and the total picture of aged care, but they look at the worst side of it.

Ms Goold—Some undergraduate students get a good deal of exposure to residential aged care in the very early part of their training but unfortunately at the moment residential aged care in Victoria does not look too good so they do not exactly see anything that they really want to go for. The other issue that exists for aged care is that it has a very poor reputation, but there are a lot of people —and I am sure Anne-Marie's figures would back this up—who would like to work in aged care. There are a lot of nurses who would work in aged care if they could afford to leave their present positions to do so.

CHAIR—Ms Scully, you wish to make a comment here?

Ms Scully—I think that there are some really positive programs going on in Victoria around this. Psych nursing in particular is raising its profile. Amongst the nurse practitioner projects was one called Psychiatric Liaison that started at a hospital because 40 per cent of those patients in an acute hospital at any one time have a mental health problem and 40 per cent of those in a mental health institution have an acute health comorbidity going on. What happened was they employed a psychiatric liaison nurse between the staff and any patient, so if a patient was admitted to the acute hospital and had a mental health problem this psychiatric liaison nurse wandered up and assisted. They sort of did the brokerage, explaining to these nurses who had no mental health background that, even though he was a schizophrenic, the situation was well under control; that he was only in for appendicitis and that he was actually not going to bring upon them—

CHAIR—That is right.

Ms Scully—And for the first time we found in a very large institution as a result of that that the nurses' perceptions of somebody with a mental health problem was not a problem. They saw that in fact they did get well and they did behave normally on some occasions. It was actually not only the nurses, it was the doctors, residents and registrars as well.

CHAIR—It was said for some time, and I would be interested in your comment as to whether it is still the case, that by and large the very significant increase in outcomes for psychiatric patients was because of the changed nursing care; that the medications had not changed very much and we did not by and large strap people up so much any more, and largely that was because, at least in the psychiatric institutions that existed under enlightened management, the nurse care was the significant factor that had changed. Is that not the case any more?

Ms Guppy—I think it is the nature of the delivery of services and the fact is that that is around the availability of acute beds. We could have a Senate inquiry into that, but I will not go into that.

CHAIR—It is on the record.

Ms Guppy—I think that it is twofold and that it is both educative and ideological approaches. It is also a societal approach to mental health issues. It is no longer *One Flew Over the Cuckoo's Nest* stuff, which did probably the greatest disservice to people with mental illness ever. So those changing things brought about better outcomes. That would be through changing education and in research informing practice in a range of institutions. Also, I beg to differ with you, Senator Crowley, about medications. I think that in the last 10 to 15 years the changes in psychotropic medications for people with mental illness have been extraordinary in terms of outcomes.

CHAIR—I did not wish to suggest that was not the case. It used to be said that the major factor in making a huge difference was the way psychiatric nurses were actually treating people with respect.

Ms Guppy—And also the change in environment. It is much easier to get outcomes if a client is in a supportive environment with their family. To take up Ms Scully's point and talk about the changes in service delivery: because we do not have stand-alone psychiatric facilities and people are presenting to accident and emergency facilities, we have accident emergency nurses. They are called ECITs—emergency crisis intervention teams—and are based in emergency. They provide a fantastic support and role model for general nurses, so they see outcomes.

Senator KNOWLES—On the issue about what people are seeing and what people perceive jobs to be, through *One Flew Over the Cuckoo's Nest* or *ER* or anything else, aren't a lot of those shows actually contributing to the problem? You look at ER and some of the other shows and the young girls are going to go into general nursing and marry the best looking doctor on the block and live happily ever after. It is all about what people have in their own mind as to what the job entails. But are we lacking within the education system a broad enough education about those particular fields?

Ms Scully—Absolutely.

Ms Guppy—With respect to the general nursing colleagues—and you would have figured this out—there is a lot of debate within nursing. Nursing is highly political. We look at streaming. Maybe there is a generic first year and then you go into psychiatric nursing. You do two years.

Senator KNOWLES—That is a good idea.

Ms Guppy—We had that. We did it well and we produced fantastic graduates, specifically in psychiatric nursing. We kind of figure, 'It wasn't broke, so you did not need to fix it,' but they did. David was less bullish about it. I think it was ideological. There was a huge political push from positions in nursing. People have the attitude that a nurse is a nurse is a nurse. They are not. People who have to go into a comprehensive nursing course say, 'I don't want to do this. I don't want to waste time.' They want to do psychiatric nursing. They know that at the end of three years they want to work in psychiatry. They do not want to be doing this other stuff. It is just time wasting. So we have a very particular view about the solution for the mental health nursing work force.

Senator KNOWLES—Would that same model work with aged care?

Ms Scully—No.

Senator KNOWLES—Because you would need more of the general combined with aged care.

Ms Goold—You would need all of the general—

Ms Scully—Because of the illness factor in aged care now. They are very ill.

Mr Stephens—Can I just pick up on one point about the graduates who undertook the psychiatric nurse training programs. They are a diminishing group. The types of initiatives that

have been put in place in relatively recent times are the ECIT, in the accident and emergency areas, and in other areas where we are seeing some good results. That is being provided by those nurses who have that psychiatric nurse training. As that pool diminishes, we are not going to have delivered in future the types of programs that we have being delivered today.

Ms Tchernomoroff—I want to make the observation that aged care, mental health and many of the other specialties in nursing that we have talked about today are suffering from the withdrawal of education and support in the workplace. These allowed people to be comfortable and to promote their own workplaces. The reason I chose my specialty, which was emergency nursing, was that there were people there with a commitment and a knowledge that underpinned what they were performing. It opened up to me a whole new range of thinking about things that I had done before. Now, with poor staffing levels and the fact that we cannot attract people into paid postgraduate programs, when people do get into specialty areas they do not see them in the way that we saw them in the past. We are not seeing specialists who are comfortable in their areas. We are not seeing the area work in the way it should. With educators on site and people there to support the beginner practitioner, that was much better promoted.

Senator KNOWLES—You are talking about the very opposite of bullying, aren't you? You are talking about people who are committed. You go in there and they encourage you, and they probably do not even know they are encouraging you, but it is because they are so committed to what they are doing. At lunchtime today, I had the pleasure of having lunch with two ICU nurses and an emergency nurse. The way in which they were committed to their area of specialty would inspire anybody. So it is the opposite of this horizontal violence.

Ms Tchernomoroff—To mentor effectively and to be able to promote your area of specialty you need to be comfortable in it and you need to have the time to do it.

Mrs Ormerod—I want to pick up on Senator Knowles's comments about aged care. Aged care is, I would say, where the majority of enrolled nurses work. That is right across the country, not just in the state of Victoria. The concern that NENA gets from colleagues within that sector is the feeling of being made to feel a lesser being. Because of deregulation, and I speak for Victoria in particular, it was seen by the government of the day as a cheaper option to employ unregulated, unqualified people. Therefore, enrolled nurses who were at that time taking on aged care—and still are—to make it something good, were never given that opportunity. We hear it every day. With the deregulation, we have the unqualified worker out there who can give out medications. Enrolled nurses, while they may have the skills and knowledge acquired during their training, cannot do some of the things that the unqualified worker can do. Therefore, they become a lesser option when it comes to employment. Something needs to occur within the deregulation of nursing homes. It is farcical that we should have quite a number of enrolled nurses seeking employment right across the country, in areas such as aged care.

Senator KNOWLES—Are you only talking about Victoria? Does it happen anywhere else?

Mrs Ormerod—No, I have to talk from a national perspective. There are enrolled nurses who really have concerns about what is happening right across the country. In all states—and we have a representative in every state—there are concerns about the cheaper option, which is the unqualified, unregulated person.

Ms Goold—From a manager's point of view, it is not simply that they are cheaper. In some aged care facilities you could afford to employ an enrolled nurse as the head of a PCA or unqualified worker, but you would not do so because the enrolled nurse is not allowed to give out medication. So you cannot possibly afford to have her.

Senator KNOWLES—PCA?

Ms Goold—Unqualified worker, patient care attendant, nurse assistant, nurse attendant—there are about 20 different titles. They are unqualified.

Ms Scully—I know as we talk about aged care we are talking about hostels and nursing homes and, in a sense, we are not addressing the issue of aged care within the acute health care system. They are treated inappropriately when they hit the emergency departments. If we hit them hard for five days, we can often get them home more well than the system allows at this time when they come in with their chronic disorders and all those sorts of things.

CHAIR—Please explain the meaning of 'hit them hard'.

Ms Scully—I have read some research which stated that if an elderly person arrived with, say, a fractured—

CHAIR—Yes, I know what you mean. You mean early attendance and rigorous attendance.

Senator KNOWLES—It is not vertical violence.

CHAIR—No.

Ms Scully—If they are on sheepskins with an IV in in 15 minutes and on the table in four hours, you get them home in under the ordinary length of stay. But part of that includes getting the pharmacist in to do a pharmaceutical review because medications are the major problem. We have a huge aged care need for good gerontological nurses in environments other than residential aged care, and there is a definite need for division 2 enrolled nurses in residential aged care.

Senator KNOWLES—There is another area of aged care where some of the nurses have said that they are bogged down compared with what happened, say, 10 years ago. Then, a pharmacist would be available to go and check medications, the OT would be around, the physiotherapist would be around—all of those sorts of things—and now those people have trickled away and that then comes back to the nurse. How do you see those good old days returning? Obviously it comes back to funding and availability of personnel, but I presume that personnel would be available if the jobs were there. What is the prognosis for returning to the good old days and how would we do it?

Ms Scully—I just do not see it happening, so I think that we have to come up with solutions for now. I would say that there are two big burdens in residential aged care. I do not know if any of you have seen it or had to do it, but the documentation in aged care is just phenomenally outrageous. In an ICU unit, I can look after a tubed patient, with a quarter of a million dollars worth of equipment, on three pages. If you admit somebody to an aged care facility, you

complete an 18-page document. I would say 27 per cent of time in aged care is in documentation, which is nursing time. Also, we should bring back the physiotherapist, the OT and the music therapist, plus more nursing hours.

Senator KNOWLES—But in this case, I am not referring just to aged care. I am referring across the board, where those people invariably took some of the demand off nurses.

Ms Scully—Absolutely.

Senator KNOWLES—I do not see a way that we can return to those good old days but if you have a solution as to how we solve it in the future, I would be keen to know.

Ms Scully—Increase the case-mix funding—increase the DRG weighting, especially for the over-75s. I know that might sound simple but even if you put a dollar on for a DRG weighting or a WEIS funding for anybody over 75—but it has to be directed at exactly what you have described—that may assist.

Mrs Goold—The other thing is that, in the good old days, the nurses were student nurses on the floor. They were the people who were providing, and there were lots of them comparative to what we have today. There was the opportunity for those people to learn on the job, to be available to do those things and to learn those skills. I think that today we would probably be struggling to get a first- or second-year registered nurse to actually provide some of those support roles, because they do not have the knowledge; it has not been part of their educational preparation. And if they come out into a non-specialist area, they are probably not likely to have the role models, mentors or teachers available to them to provide that sort of support.

Senator KNOWLES—What I am talking about is also having physically on-site the physiotherapist, the OT, the pharmacist and so on who used to be there. Sometimes they are there now, but it is only one pharmacist and they cannot leave the dispensary in the way in which they used to.

Mrs Ormerod—Are we talking about in the acute sector or in aged care?

Senator KNOWLES—No, I am talking right across the board.

Mrs Ormerod—I do not know. I have never actually worked in aged care. I have only ever worked in an acute facility as a division 2 nurse and we have got all of those in our facility—the physiotherapist, the OT, the dietician; we have got all of those. We do not have them in aged care.

Ms Goold—But you might not have enough of them.

Mrs Ormerod—I know that we do not.

Senator KNOWLES—But they are not going around to the wards the way they used to.

Ms Scully—No, they are not. Again going back to medication issues, as you know, I believe the risk and quality issues around medications are because of the absence of pharmacists from wards and units in the acute sector now. We are seeing 30 to 40 drugs a month come on the market. The doctors and the nurses cannot keep up with it, and their biggest resource has been reduced to looking it up on *MIMS* on the Net.

Ms Goold—It may depend on the facility. For instance, last year when I was managing 10 beds at the Alfred, the average number of patients that our physio had in the hospital at any one time was 60. I had 10 complex care, usually aged, patients for that physio to look after. There is no way they could look after 50 others at the same time, not with the workload they had.

Ms Stickland—I would just like to reiterate Anne-Marie Scully's point about the DRG and casemix funding to individuals in hospital. We certainly do not have the number of allied health professionals that we used to have at the bedside in the good old days, and that really comes down to the price on the care of that individual as they walk through the door. The majority of the care is at the bedside, so the nurses are pretty much there, even though understaffed, for those positions. Alongside that is also every other allied health professional, pharmacists included—and even dieticians, social workers, occupational therapists and pastoral care workers—all providing what they are meant to be providing: the care that is optimum, but on limited financial resources, because they do not actually have as many people to do the same job as they did. It does come down to the actual price of admission of the person and what it costs to look after them.

Ms Schroeder—My thought was that in the good old days we, the nurses, gave all of that care. Gradually all of these people came up. They got more professional recognition than nurses ever did, and a better salary. No wonder we do not have so many of them, because they cost more than we do. Now it is turning back again: we pick up their jobs.

Senator KNOWLES—Good point.

CHAIR—I want to switch and go back to a couple of other things. If there is something you absolutely have to say, can I ask you to say it at the end, because I want to put these next questions. I am interested in the nurse-patient ratio then and now. In the good old days, when you said nurses were on the floor doing all those things, how many were there per patient? We have to remember that I am older than everybody and then Methuselah, and I was back there when we had one almoner for the whole 600 patients in one hospital, and they were called almoners. So that is definitely 19th century—and I hope Hansard understands heavy irony. Can you give us a small sense of what it was like in, say, 1980? Do you have any figures that might help us? We do talk about our experience or our contemporary's experience, and that is called 'then' or 'when it was better' or something. Do you have a nurse-patient ratio now as compared to then?

Ms Scully—We can go back to 1973, if you like.

CHAIR—That would be good.

Ms Scully—In 1973 you would often have on night duty one student nurse—because we were not in the university—to 13 or 15 patients. There were two registered nurses for the entire

hospital at that time, who were responsible for all the student nurses working on the ward on night duty—that is why they all took up smoking. After the education was transferred to the universities and we had an 'all RN work force', as they would phrase that, and enrolled nurses, we had a ratio on night duty of one to 15, and during the day it would be anything from one to eight to one to 10, and occasionally plus, in charge. That may have been fine when there was rest and recuperation time, so that in fact the workload was fairly gently curved. As we moved towards economic downturn in health, there was the introduction of casemix funding, the number of nurses was not increased, there were shorter lengths of stay and higher acuity, and we found that in the acute sector in Victoria during the day we were looking at one to six or one to eight, but at night it was still one to 10 to one to 12. I am talking about the acute sector, the public sector. It was impossible. Now we have it one to four plus in charge on the morning shift, one to five plus in charge on the afternoon shift and one to eight on night duty.

CHAIR—So 'in charge' means the unit head honcho?

Ms Scully—The nurse unit manager or the associate nurse unit manager is excess to that.

CHAIR—That does make for very interesting comparison, and I think we do need to bear in mind that sometimes the good old days are a rosy glow on a rotten situation.

Ms Scully—Absolutely.

CHAIR—At least sometimes. You spoke earlier about the no-lift policy. These are questions from across the field, so they have no lovely, coherent logic; forgive me. Do you have any evidence that the no-lift policy has actually reduced accidents? You said it had; was that hard data evidence or is that anecdotal?

Ms Scully—Yes, and I can provide that to you.

CHAIR—That would be very useful. Is it fair to say, as we were told in Western Australia—or at least we got the impression in WA, and maybe that was just us talking about it rather than hard evidence—that the no-lift policy is often more honoured in the breach? That is, if she is about to fall out of bed or he is about to hit the ground, you do not really say, 'One moment, while we get the hoist,' and then do the elegant and proper thing. People do put their shoulder into the lifting or whatever—I do not know how to lift properly so I do not know the right language. Is it true that it is now a 100 per cent no-lift policy or is it sometimes absolutely essential to do something immediately and without the assistance of machinery?

Ms Scully—It may be but we have had a very intensive and very educational program for manual handling and how to deal with those emergencies when you find someone on the floor or, when they are falling, how you go down with them—how to protect yourself in those sorts of things. It is a very good education program. There is a variety of them and I can give you the hard data on that as well if you like.

CHAIR—We would appreciate that data. That would be very useful indeed. We have been hearing about nurse banks. I presume nurses in the nurse bank are paid on casual rates?

Ms Scully—Yes.

CHAIR—Are they being paid superannuation?

Ms Scully—Yes. They are employed by the hospital.

Ms Goold—They have all the same privileges as a normal worker, except that they are a casual.

CHAIR—Only when they are working?

Ms Goold—Yes.

Senator GIBBS—So they are permanent casual, in other words.

Ms Goold—Yes. They do not have set hours—the hours will vary from day to day and week to week—but they are in fact an employee of the organisation.

CHAIR—They are not getting a casual loading; they are actually getting the ordinary salary. Is that right?

Ms Scully—No, a casual loading.

Ms Schroeder—There is no annual leave, no long service accrual and no sick leave accrual.

CHAIR—But they are getting super.

Ms Schroeder—Yes.

CHAIR—Is there a piece of paper that would spell out exactly the terms and conditions for the nurses in the nurse bank? I can see nurse banks would be a help for some people but it may be that some people are disadvantaged under those conditions in terms of wages and conditions.

Ms Goold—Nurse banks are not new. I started training in 1974 and I have never worked in a hospital in Victoria or Queensland that did not have one, so they are not anything new and they are not some wonder drug that the Victorian government has found all of a sudden. They are no different. The difficulty for people who work on nurse bank is that you cannot guarantee them any time. Whilst they might like some varied times, they are not always available when you have times to offer them. A lot of those people choose to work through an agency as well, which will give them more access to work.

CHAIR—I want to go to this interesting notion of shortages of nurses across the world. Senator West and I visited the UK last July and spoke to the nurses, the union representatives and the politicians involved in the UK inquiry and discovered that they are advertising like mad to get nurses from Australia and Canada. I went at some stage to Canada and—would you believe?—they are advertising for nurses from England, Australia and New Zealand. Some people are actually advertising for nurses from the Philippines and South Africa. So it seems to me there is an absolute shortage everywhere so that everybody is poaching everybody else, and it certainly seems to me that there is just a group of nurses going around in a circle.

I want to know how you measure a shortage. Everybody says there is a shortage. If the UK has a shortage and they poach nurses from Australia, of course we will have a gap. We will fill our gaps with nurses from Canada; that is all right because they have just got them from the UK. In the end, you could be left concluding that there is not a shortage, they are all just working in a different country. To what extent can you tell me there is a shortage versus just a large number of nurses on the rove?

Ms Scully—I think the vacancies more than anything else would demonstrate to you the shortage—where we lack nursing staff to fill vacancies. We can provide details of vacancy rates and continuing vacancy rates. For example, I am sure you know that public hospitals are allowed to advertise overseas if they can demonstrate to the satisfaction of Foreign Affairs that they have advertised for three consecutive weeks in the newspaper and not had any responses for six months, and those sorts of things. Hospitals, for the Department of Human Services, now keep figures for vacancies. As for the private sector, we would have to go to private sector representatives and ask them for their vacancy rate, remembering that they often run on an employment basis that used to meet their admission rates, so I am not sure about the private sector but I do know that they have problems as well.

Ms Goold—The other difficulty with nurses who come from overseas is the amount of time they are allowed to spend with one employer. Currently, that is three months, so every three months they up and move to somewhere else, which does not leave you much hope if you have employed them or put them on your nurse bank. You all of a sudden have a vacancy again 12 weeks later.

CHAIR—We have heard a lot about the need for hospital health to talk to or interface with universities. Points have been very powerfully made today about the role of TAFE, which has been in large part overlooked in our inquiry, or tends to be easily overlooked. What is the interface between hospitals and TAFE, or the health department and TAFE? If none of you can answer this, that is fine; we will then put it to the department. Do you know anything about the relationship between TAFE and the universities or is that something that would have to go up through the health minister and out again?

Ms Goold—In the aged care sector, TAFE provides all the training for the PCAs before the assistance in certificates II, III and IV. They provide training for ENs as well. My feel would be that their interaction with the universities is fairly limited. There does not seem to be a working party that talks together.

Ms Scully—There are some universities which now have TAFEs as part of their campus and they of course have a very different relationship to universities that do not. For example, Victoria University here in Victoria has a TAFE sector and they interface fairly well. For freestanding TAFEs and universities, this is a difficulty, it is longstanding and historical, and I do not think there has been much to address it. One of the problems we have with TAFE and division 2 here in Victoria is the fact that under the previous government they had to put education out to contractual tendering, which resulted in lower and lower bids so that now the amount of funding they are trying to provide this education on is very low, so we have great problems there. We were the first state to introduce traineeships for division 2, which was quite successful, in an attempt to address the closure of the Melbourne School for Enrolled Nursing. We would say we are 800 positions behind TAFE for division 2, but we do not have the funding

for it. That is how much catch-up we need. The interface with the acute sector is very low because most of the clinical placements are with aged care; if they are a rural hospital it is a tad different. Some acute major hospitals have toyed with the idea of becoming RTOs, registered training authorities, so that they can commence once more their own training schools for division 2, in an effort to try to do something about their vacancy rate.

CHAIR—That is very useful, thank you. If there is any further information about how these different institutions speak to each other, that would be very useful. That is something I believe we should probably put to the Victorian department. Mr Stephens, I cut you off before. Is there something you would like to finish saying or would like to add in terms of the TAFE question or how these different parts of the education of the nurse work force talk to each other?

Mr Stephens—I do not think I could comment on the latter but there was a matter which I wanted to pursue with respect to a question from Senator Knowles; that is, the concept of going back to the good old days, that type of arrangement—or back to the future, if you like. We see that going back to the good old days does not necessarily mean that it has to be a retrograde step. It certainly does not mean that at all. Our grandparents would never suggest that going back there was a bad thing.

What we do know about what the good old days represented from the mental health perspective, and I guess every other area as well, is that the education components worked. It is not a retrograde step to go back or to put in place an adequate education system that provides for graduates of nurse programs to come out as competent and, importantly, safe beginning level nurses. That is not a retrograde step. We can do that because it is certainly not beyond the wit of anybody to develop the course programs. Indeed, in 1997, the then Kennett government in Victoria developed what it believed to be an appropriate mental health course content in response to a failing undergraduate course program at that time, and that program still continues to fail us. The good old days really do represent what the future should be, and that is, adequate education.

CHAIR—Where that is the case, I think your point is very well made. Thank you.

Senator KNOWLES—Did you say that program continues to fail us?

Mr Stephens—With what we have at the moment, the comprehensive nursing education training program continues to fail us.

Senator KNOWLES—But hasn't it got that component now in?

Mr Stephens—No. It was put up in a discussion paper at the time in the context of whether we should go to four years, whether we should we review this or that.

Senator KNOWLES—It got knocked on the head.

CHAIR—We have heard about people doing occupational health and safety things—for instance, trying to save on backs. The cost benefit is interesting, because we know if a nurse does not break his or her back, it is of considerable benefit to the community. For example, a hospital can go to considerable outlay to get no sharp needles, to be a needleless society—a

pointless society. There is increased cost to get retractable needles or sharps, and things of that sort. If these things are put in place, they are going to be a cost outlay to the hospital or the institution. Where does the benefit go? If, for example, 80 nurses now do not get stick or prick injuries, is that a benefit to the hospital? Do they have less sick pay? Do they have less time off? Do they have to pay fewer staff? And do we have that actually quantified somewhere?

Ms Scully—Yes, but we are using American figures at the moment, because only one of our hospitals has introduced the retractable needles. What we can demonstrate for you is the number of needle-stick injuries, remembering it is not nurses alone. It is theatre orderlies—anybody who is at risk of a misplaced needle.

CHAIR—Also, if you have got OH&S savings for backs or if you reduce the violence, for example, or the bullying. That is probably a harder one to quantify, but it is a terribly important point in terms of these changed practices that are actually producing a hard economic benefit to the institution. That is an equation that would be of help to us.

Ms Goold—There are also figures for organisations that are using plastic needles rather than needles that are not just retractable, which are very successful.

CHAIR—We have had a fantastic session. I want to thank you very much. It is hard to try and give sufficient justice to the people who go to the bother and put in the effort and time required in making submissions to inquiries. My understanding is that just about every nurse in Australia must be sick of writing submissions to the two, three or 10 inquiries that are currently or nearly currently under way. Senator Knowles made a very important point in terms of the focus of our inquiry in particular. I do want to thank you, in the light of all those other calls on your time, for your contribution here today and for your preparedness to come as a panel of witnesses rather than as individual witnesses. It is a great benefit to the committee and we thank you very much.

Committee adjourned at 4.39 p.m.