COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## COMMUNITY AFFAIRS REFERENCES COMMITTEE

**Reference: Nursing inquiry**

THURSDAY, 21 MARCH 2002

CANBERRA

BY AUTHORITY OF THE SENATE

**SENATE**

**COMMUNITY AFFAIRS REFERENCES COMMITTEE**

**Thursday, 21 March 2002**

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

**Participating members:** Senators Abetz, Bartlett, Bishop, Calvert, Carr, Chapman, Coonan, Crane, Crossin, Denman, Eggleston, Evans, Faulkner, Ferguson, Ferris, Forshaw, Harradine, Lightfoot, Mason, McGauran, Murphy, Payne, Tierney, Watson and West

**Senators in attendance:** Senators Crowley, Knowles, Lees, McLucas and Tchen

**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 3.34 p.m.**

**BOOTH, Ms Deborah Louise, Deputy Director, Integrated Health Care Program, ACT Community Care**

**BYRNES, Mrs Susan, Clinical Nurse Consultant in Maternal and Child Health Nursing, Child, Youth and Women's Health Program, ACT Community Care**

**McDONALD, Ms Heather, Principal Nurse and Director, Clinical Effectiveness and Quality Management, ACT Community Care**

**KIDD, Mr Kevin Michael, Acting Professional Head, Mental Health Nursing, ACT Mental Health Services**

**KIRK, Ms Mary, Director of Nursing, Queen Elizabeth II Family Centre and Representative, Focus Group of Specialist Nurses**

**McQUELLIN, Ms Carmel, Representative, Focus Group of Specialist Nurses**

**CHAIR**—I declare open this further hearing of the Community Affairs References Committee's inquiry into nursing. I welcome representatives from ACT Community Care, ACT Mental Health Services and the Focus Group of Specialist Nurses.

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 will give consideration to your request. The committee has before it your submissions, numbered 810, 777 and 783. Do you wish to make any alterations to these submissions?

**Ms Kirk**—No.

**CHAIR**—I will ask each of you to make a brief opening statement and then field questions. We have had a considerable response to this inquiry. We very much appreciate your interest. We are trying to give as many witnesses as possible the opportunity to come before the committee, so we appreciate the opportunity for this panel type arrangement. If you wish to comment on other people's contributions, feel free to do so.

**Ms McDonald**—Community and primary health care is an area of specialty that has been neglected by both tertiary and government sectors for some time. I think it is really important to recognise that community health is a nursing specialty and should be treated similarly to other specialty areas, such as in the acute care setting. At the moment there are dozens of postgraduate courses that are available to support them, but this is not the case in community nursing. More and more community health organisations are being asked to provide post-acute services to clients because of their early discharge from acute settings. What has happened is that the focus on the nursing in the community has become much more on post acute, rather than on recognising the primary health care that is crucial to the wellbeing of the community. The funding is not there, particularly in our organisation, for our nurses to provide both. This

has led to the primary health care focus being decreased and a greater emphasis being placed on post-acute care.

We need to foster a culture of research and the use of evidence based practice within the community. One way to achieve this is to increase the numbers of joint appointments between the agencies and the universities. This needs to be at a high level, like a professorial level. This would provide an opportunity for both us and the universities to build and sustain a closer relationship. This would assist in the promotion of better evidence based practice for our nurses.

A more structured pathway for nurses needs to be in place for them to remain within the clinical stream. This needs to be supported both financially and politically. This would include support for more nurse practitioners. We need to have a career pathway which would recognise clinical expertise and enable practitioners to remain in the clinical setting but still be able to pursue career progression.

I think it is of great importance that we are able to maintain a skilled and flexible work force. This would be enhanced with an infrastructure that would be able to respond to the changing trends and needs of the work force. Undergraduates and new graduates need to have a wide variety of settings in which to make career choices that are informed. I think we have to recognise that the younger people coming through the work force today are not expecting to stay for a long period of time, and we need to recognise this and plan accordingly to target the different groups of people that are coming through.

**Mr Kidd**—The opportunity to address the committee and speak to the submission is very much appreciated by ACT Mental Health Services. The national inquiry into nursing is to be applauded, and much is expected of it. However, with the gravity of the problems occurring now, it is not notional; it is a daily event. The delivery of quality mental health services relies heavily on the availability of a sustainable mental health nursing work force. Services do what they can to be novel, innovative and responsive; however, our collective experience indicates that what is required is a nationally coordinated, well-resourced strategy, not piecemeal attempts by individual health services conducting robber baron campaigns. The health system now trades heavily on the goodwill of its existing nursing staff. In turn, there is a growing acceptance among those staff that this is as good as it gets. This is insidious and, worse still, it permeates the consumers of health services.

Based on the here and now of the problem, the submission provided to the inquiry by ACT Mental Health Services is essentially pragmatic and is not intended to convey a level of sophisticated analysis of the problems facing nursing, as these are well documented and have been well addressed by others. This submission is intended to show that there is an ability to mobilise an existing, identifiable group within the nursing work force to offer a way forward in the shorter term. The thrust of the submission is to recognise that there is an ability within the nursing work force to increase the supply of registered nurses by bridging the qualifications of enrolled nurses. This is not a new idea and has been advanced by many others. However, to our knowledge it has not been implemented, chiefly because it is cost prohibitive.

We offer no apology for the submission's uni-dimensional nature, or that it relates to short-term benefit or that it is simplistic. The funding by the Commonwealth of such a simple solution

is precisely what we believe is required. We are also, however, appreciative of the need for thorough analysis and well-considered recommendation matched by increased funding. Strong leadership is also a commodity that is required, as well as cooperation from all states and territories.

What we have with respect to mental health nursing is the potential to bear witness to the loss of a nursing specialty within the next 10 years. Mental health nurses exist in comparatively small numbers and, based on present trends, we are unable to propagate in order to survive. The evidence suggests that when mental health nurses are absent novel solutions are found by readily replacing them with other workers. This has been applied in both community and hospital settings. This in turn creates a self-fulfilling prophecy wherein the absence of nurses is no longer relevant and given little ongoing consideration.

The above scenario has not been allowed to occur in the ACT as it has in other jurisdictions. It needs to be said, however, that what is an already difficult situation here in the ACT is further compounded in that comprehensively trained undergraduates, or for that matter experienced general nurses, require an additional mental health nursing qualification to practise. This is not the case in New South Wales, as there is one register. I am also aware that there are cogent arguments being made to adopt a separate register approach in jurisdictions where they no longer exist. We would regard this as being done at peril. The question to be asked of pragmatists is: what have you done?

We have not been in a position to embark upon an EN bridging program as it is cost prohibitive and in the mental health services it is not feasible to initiate or implement. We have, however—and I know we are definitely not alone in this—implemented two programs. Both relate to postgraduate courses with registered nurses and enrolled nurses, both of which cannot be offered in the ACT and are provided through the University of La Trobe, Bendigo campus. Places in these programs are limited, as is the funding. It is not expected that these in-house programs by themselves will stem the tide. However, they do offer a way forward. We will continue to make the argument, however, that a sustained supply of registered nurses who bridge their qualifications offers a viable path, and it is one option that the Commonwealth should seriously consider funding.

**CHAIR**—Can you fill me in on where you get your nurses from? Is it from La Trobe, or is that only for postgraduate?

**Mr Kidd**—We fish for them, as do most states and territories. As I said, the approach is largely robber baron campaigns—who can out-offer who what in a diminishing resource base. So we get people where we can find them, quite literally. We are a small entity within service provision but, as most people know, mental health conditions affect one in five. So the demand on our resource base is increasing and a better than 50 per cent part of the work force is diminishing—

**CHAIR**—I do not want to go into all of that, Mr Kidd; we will come back to those questions. Could you just tell me what I was not hearing about the reference to La Trobe?

**Mr Kidd**—We source our postgraduate academic program through La Trobe University.

**CHAIR**—All of ACT nursing or only ACT mental health nursing?

**Mr Kidd**—Only ACT mental health nursing.

**CHAIR**—Thank you very much. Last but not least, I invite the Focus Group of Specialist Nurses to make an opening statement.

**Ms Kirk**—On behalf of the focus group of maternal and child health and women's health nurses, I thank the inquiry for this opportunity. This response drew upon contemporary evidence and is presented following deliberations of the focus group aimed specifically at the terms of reference of the inquiry.

In relation to specific causes, and the role and place of nursing in the Australian health care context, nurses believe that these give rise to role conflict, role strain, role ambiguity and role overload. We attest that the shortage of skilled nurses is complex and includes growth in demand for health services, declining numbers of students to undergraduate and postgraduate nursing programs, an ageing skilled nursing work force, increased job opportunities for graduates, reduced opportunities for career progression within the professions of nursing and midwifery, and lack of support for ongoing professional development.

These factors, together with issues particular to a female dominated profession and significant strategic changes in the allocation and distribution of health resources, have had significant impacts on the current nursing shortage. As a female dominated profession, the majority of nurses carry the dual role responsibilities of work and family. We believe little has been done in the past 20 years to support them in handling the competing demands of career and family. The constant downsizing and restructuring of health services, both acute and primary, indicates to prospective students of nursing that opportunity for advancement and reward is limited and nursing is therefore an undesirable profession.

Client complexity in all health sectors has been rising rapidly, with the result that clients with increasingly complex care needs are also being cared for by nurses in the community setting without systems which support, value, recognise and reward the role of the nurse.

Enrolment in nursing programs is on the decline, due to a variety of factors which include but are not exclusive to the decimation of career structures and opportunities for progression, reward and conditions which are not commensurate with those of graduates from other professional programs, and the image of nursing within the profession and the community. If we are to attract and retain the quality of young people to the profession which the community requires for high standards of health care, there must be a political will to undertake comparative worth assessment and reward nurses accordingly.

In relation to specific impacts, we believe there is direct evidence that the provision of care by nurses, and not unregulated workers, results in a significant reduction in adverse events. Replacement of nurses by non-regulated workers has resulted in a decline in care standards and a concurrent rise in adverse events. With changing career and organisational structures, nurses are increasingly being managed and controlled by those outside the profession. Nurses commonly experience role difficulties around authority, autonomy and linkages to

empowerment, leaving them in the untenable situation of responsibility without authority. Nurses neither value nor feel valued by the systems within which they work.

The group also believes there needs to be opportunity for nurses to lobby and advocate for nursing at federal and state health department levels. If we are to invest in quality health into the future, then current funding systems for nursing education must be replaced with systems that are strategically sound, as opposed to those that are driven by short-term economic imperatives. While financial rewards are not commensurate with those of other professional groups, nurses cannot expect to bear the financial burden of continuing education. Currently, lifelong learning is at the cost of the nurse for the benefit of society. Now is the time to create systems that reward further study, to keep these experts in the profession.

I turn to specific strategies identified by the focus group. We believe it is important to look at not just options for family friendly strategies but also strategies that recognise the many varied roles women fulfil in Australian society. Nursing is a female dominated profession working within the social construct of the Australian health care system. How a society values its nurses is generally how it values its women. Therefore, there is an urgent need to recognise and value women's role in nursing and in society.

Education is the foundation of professional development and a key to empowering the nursing profession. Barriers to education for nurses must be removed to ensure nurses reach their full potential. Education programs must be affordable to a female profession, and career structures and organisational structures must be developed that reward commitment to lifelong learning. Organisational structures need to be redesigned to achieve a shared governance model. To be successful, a governance model must be in an environment that empowers nurses through the delegation of resources to assume legitimate authority and responsibility for the practice of nursing.

I turn to specific strategies to improve occupational health and safety. There needs to be a national strategy to address issues of violence experienced by nurses. Nurses working in primary health face particular safety risks in relation to working in isolation. Workloads across all sectors must be addressed in relation to job dissatisfaction, absenteeism and turnover. We also believe that burn-out is the consequence of specific social and situational factors that can be changed, and social support in the workplace is an effective tool for offsetting burn-out in nurses.

Resources need to be allocated to the benchmarking and application of standards which relate to nurses' safety and lifting. We also believe that research into workplace design and building standards needs to be conducted to ensure safer workplaces which are efficient and effective to carry out nursing work. Particular attention must be paid to the environments of nurses working in the primary health sector.

**Senator LEES**—I want to look at specific courses for community health here in Canberra. Is there an option for students to—

**Ms Booth**—Not in community nursing, no.

**Senator LEES**— In some universities there is at least an option where they can choose between—

**Ms Booth**—There used to be a community nursing course until about 1989. Then it got amalgamated into the general course. You could take either the child, youth and family stream or the gerontology stream, but that was abolished.

**Senator LEES**—So your organisation does not at any stage have student nurses out with you?

**Ms Booth**—We do. We have undergraduates with us, but they do two days with us.

**Senator LEES**—And is that—

**Ms Booth**—Over their three years. It is not enough.

**CHAIR**—Two days in three years.

**Senator LEES**—Perhaps we need to ask some of these questions of the university, but you say there is no mental health experience—no course or no specific training here?

**Mr Kidd**—No course, no.

**Senator LEES**—Do you see any students at all?

**Mr Kidd**—We have students that undertake our own program, but we source the academic part through La Trobe. We also have undergraduate students who attend our services from Canberra University, as well as from La Trobe and Charles Sturt University at Wagga.

**Senator LEES**—Are there any opportunities in any of these fields for re-entry courses for nurses who have perhaps moved out of the profession or come from elsewhere?

**Ms McDonald**—Yes. There is a refresher course that is available. The ACT government has actually funded places for the refresher courses to help with the nurses coming back into the work force.

**Senator LEES**—So do you see people out of those refresher courses?

**Ms McDonald**—No.

**Ms Booth**—They go to the acute care setting.

**Senator LEES**—They go into an acute care setting?

**Ms Booth**—Yes.

**Senator LEES**—So if a nurse was not comfortable with, say, the hours or whatever there, is there no other course in aged care, community care or mental health where they can refresh to go into those areas?

**Ms McDonald**—No. Also, there is a lack across the country of distance education for community nursing. There are a lot of distance education courses for nurses across the country but there are only two or three suitable community nursing courses.

**CHAIR**—Where are they, Ms McDonald?

**Ms McDonald**—Charles Sturt offers one; Armidale.

**CHAIR**—Charles Sturt and Armidale are two good examples of those?

**Ms McDonald**—Yes. With the scholarships, some of our staff have taken them up and they are doing generalist masters and using that to get their community nursing. But it is just their research that they do that is specific for our needs. It is not enough.

**Senator LEES**—So when you are looking to recruit more nurses to your service, are there generally enough available in the ACT that you can then upskill to—

**Ms McDonald**—It depends on what area. For our generalist community nurse we have enough, but for our specialty area, child, youth and women—

**Mrs Byrnes**—There is extreme difficulty in recruiting local nurses to the specialty practice of maternal and child health nursing.

**Senator LEES**—What about midwifery? Do you recruit midwives into that service?

**Ms Kirk**—We do, but midwifery is facing a similar issue. The AHMAC work shows that there is a national shortage of midwives, so it flows on.

**Senator LEES**—Is there a midwifery course here in the ACT?

**Ms Kirk**—Yes, and we see those students within our settings as part of their programs. The majority of them will go on to practise in the acute setting.

**Senator LEES**—I am just looking through some of your submissions. There are a couple of mentions of students and the need to look at young people coming out of schools. Are your settings suitable for work experience—say, those in years 10 or 11 so that they can get some idea of what it is like to be a community nurse?

**Ms Kirk**—We provide it at QE II in vocational programs.

**Ms McDonald**—In our generalist adult community nursing we have some ambulatory clinic type situations. That is perfectly suitable for students to come through, because they are not going to be sent out on their own with community nurses.

**Ms Kirk**—Just in an observation role.

**Mr Kidd**—Mental health has great difficulty in that area because it is a specialty within a specialty. With respect to workplace experience for school leavers, we have significant constraints in terms of confidentiality provisions.

**Senator LEES**—Are you able to work within the hospital setting, for example, to give nurses who are beginning training some idea of what the options are?

**Mr Kidd**—Yes, in terms of the general ward areas. But where we have a dilemma is with the age and maturity of the people and the sorts of situations that we could potentially expose them to.

**Senator LEES**—Finally, you mentioned that you know some of these nurses are not going to stay in the profession. Does that mean they are simply leaving it because it is not suitable or are they moving out to have family and coming back?

**Ms Booth**—They move to different areas. They might go into nursing informatics, they might go into the university sector and come back out again or they might go and have their families and come back. Ours are some of the most family friendly hours. It is most often nine to five, Monday to Friday.

**Senator LEES**—That is particularly why I was asking about the retraining options for women who are now out and who do not want to go back into a rotating roster system.

**Ms McDonald**—Traditionally, people have been prevented from coming to community nursing early in their careers. People have assumed that you have to do an acute care setting before you come into the community setting. I think we need to recognise that it is a different area of nursing. We do not need burnt-out acute care nurses in our organisation. We actually need people who want to have a primary health care or community health care focus. We need that early in their training so that people have an informed choice that that is an option for young people coming through.

**Ms Booth**—Some streaming could occur early in, say, the second year of nursing so that they recognise that they do not want to go to the acute care sector, that they just want to come to the community sector. It would be more useful for us to take them and train them through in primary health care before they get tainted almost by the acute care setting, fatigued and generally disillusioned before they reach us.

**Senator LEES**—From earlier hearings it seems that one of the issues is not just the drop-out rate during university but the drop-out rate in that first year after university. Perhaps we could look at some of these options later.

**CHAIR**—Can you guarantee that any of the nurses, whether they are streamed early or streamed late, who come to work in the community are not going to face an emergency? Somebody might have a hypo or a heart attack.

**Ms Kirk**—They can be educationally prepared for that.

**Ms McDonald**—We have got graduate nurses coming through our organisation now. It is the first time we have done it. We rotate them through the acute care setting. We have a partnership with the Canberra Hospital. Its new graduates come out to our organisation and we employ them after the first year. So they do some of that acute care setting, plus we have got an education program and we teach them how to deal with an emergency.

**CHAIR**—I just wanted to get that on the record, because there could be a sense that community nursing is a gentler, kinder life and nothing terribly frightening or dramatic happens.

**Ms McDonald**—I think it also has to be recognised that we are dealing with very post-acute care people. We are dealing with people two and three days post surgery. So what used to happen in the hospitals is now happening in the community. We have to recognise that we need a highly skilled work force, and it is another option.

**CHAIR**—Ms Kirk, you were going to add something.

**Ms Kirk**—I would like to emphasise the point that the complexity in the community is equal to that in the acute care setting. I think there is always an assumption that it is a soft option. There is nothing soft about it. Increasingly, even technology-dependent people are cared for at home now. We might have deinstitutionalised the hospital but potentially we have institutionalised the home. It is the nurses in the community who are caring for these people. It is complex work.

**Senator KNOWLES**—One of the things that I think we have come across in all of our discussions thus far is that there is clearly a shortage of mental health and aged care nurses. That is not to say that there are not other shortages as well. Specifically, how do you think more can be attracted to those specialties, given that the evidence we have had everywhere else is that the nursing schools are oversubscribed? That runs counter to some of the things that are in the submissions. It is repeated through all of the submissions that there needs to be a greater carrot to attract people into nursing. From where I sit, it seems as though—and I have changed my view on this because I thought that there were not enough people actually applying—there are plenty of people wanting to get into nursing. Every state that we have been to has said that there just are not enough places for those who are wanting to do it. But then we go to the further stage of how we encourage some of those people to specialise in those fields of aged care or mental health.

**Ms McQuellin**—So much of it has got to do with the image of different subspecialty areas within the discipline and the image of nursing broadly. Certainly, education is such a critical imperative to look at trying to attract and retain staff, but it is not the answer in isolation. I think it is a much deeper issue and you cannot look beyond the conditions in which people are trying to work, their sense of valuing and having respect for the work that they actually do on a day-to-

day basis. That is both from the point of view of the community at large, our society, and within organisations as well. There are a lot of other complex issues that really impact. The image certainly is a critical factor, I believe.

**Senator KNOWLES**—Isn't image a critical factor for nursing per se, but it probably becomes more critical for those who you would like to see specialise in those two specific areas? We have even talked at previous hearings about the adverse effect of television shows on the perception of nursing—for example, unless you hook on to this year's doctor in the first day of nursing you are an absolute failure. But what we are looking at is the reality of how we get these people to specialise.

**Ms Kirk**—If you look at the area of nursing where the reward is least, as in pay and conditions, you go to the aged care sector. That is the reality for them. People will go where they will get the most reward, I believe, as well as—

**Senator KNOWLES**—It is not just a monetary thing, is it?

**Ms Kirk**—No, it is not. It is conditions. It is broader than just the monetary thing. That is why we were speaking about the systems that they are working in, the rewards that are there, the image of the work they are doing and how valued it is. If you want to talk about ghetto areas, in nursing the ghetto areas are aged care, mental health and then we start moving through the community sector. The areas that are the most sexy would be intensive care and emergency. That is the reality.

**Ms McDonald**—But it is also about the training. People are exposed to aged care settings in their very first year in communication skills, where they learn to talk to somebody. They do not go back there and learn their time management. That all happens in an acute care setting. They are not actually encouraged to think about aged care with a different hat on.

**Senator KNOWLES**—But that comes to the problem, doesn't it? Are they getting sufficient exposure to positive role models early enough in the training system so that they look at these people and say, 'I wouldn't mind doing that'?

**Ms McDonald**—That is right; it is a stimulating job.

**Senator KNOWLES**—It is not just a case of bedpans and crackers people. It is living a life for a whole lot of people.

**Ms McDonald**—That is right. I think we have to look at the education for some of these issues. I think that is where we start. If that is the place where you go and talk to old people, that will not encourage people to go back there and work. They go to the hospitals for their real hands-on stuff. We suffer with the same thing, because they do not come to us for any reason. But we have to change the education system to make it a sexy, attractive career path for young graduates.

**Senator KNOWLES**—I think it was in Melbourne, wasn't it, that we had some really whiz-bang people who decided that they would actually take on the role almost of mentoring young

people to look at these two particular areas and see that it was not just a case of emergency and intensive care that were the sexy ones; it was a case of saying, ‘We’re young. We’re in aged care. We’re in mental health. It’s a very rewarding occupation.’ Collectively—and when I say ‘collectively’ obviously I mean the profession, government and everybody else in the community who is involved—there is a lot of work to be done to find ways of attracting people. If I have a mission achieved out of this inquiry it will be finding out from people like you how we get those people to those specialty areas.

**Ms Kirk**—Can I comment on your comment about attracting people into nursing graduate programs. It is not just about attracting people into graduate programs; it is about attracting quality people into nursing graduate programs. You can lower scores to zero. You could lower scores for medicine to zero and you would have more wanting to get in than you want. Nursing needs quality young people to do nursing.

**Senator KNOWLES**—I could not agree more. But are you saying to me in that—

**Ms Kirk**—Some schools have lowered their scores to the point that you wonder who we are prepared to educate as nurses.

**CHAIR**—Which schools?

**Ms Kirk**—I understand some of the schools in Victoria.

**CHAIR**—In Melbourne?

**Ms Kirk**—Yes. My understanding that La Trobe in particular is one.

**CHAIR**—La Trobe has lowered its entrance scores in order to attract students?

**Ms Kirk**—Yes.

**CHAIR**—We will follow that up.

**Ms Kirk**—Some schools, yes.

**Ms McQuellin**—It has been an issue for a number of years with the competition to try to attract numbers and to maintain the viability because there is such a wide choice for students exiting school these days as to career options. Unless we can do something about image in relation to nursing and conditions and putting in succession initiatives that actually attract, retain and value the work of nursing, it is not an attractive career option for people. It is too hard a slog.

**Senator KNOWLES**—But are you actually saying to me that to your knowledge the schools are not necessarily oversubscribed—that is probably the wrong word.

**CHAIR**—More applications than they have places.

**Senator KNOWLES**—It is actually a case of that only being the result of lowering the score.

**Ms Kirk**—I am saying lowering the score certainly influences the numbers who want to do it. It becomes an option where previously it might not have been.

**Senator KNOWLES**—Surely, at the end of the day, that would also contribute to a drop-out rate, wouldn't it?

**Ms Kirk**—Yes.

**Senator LEES**—Apparently it contributes to the drop-out rate, particularly relating to those who simply cannot pass the mathematics components and components relating to medicine.

**Ms Booth**—Anatomy.

**Senator LEES**—So that does exacerbate a drop-out rate at the end, which brings us back to the schools. Looking specifically at the ACT, what is being done at school level in the ACT to get people out to experience your workplaces or nursing as a whole? Are you aware of anything that is being done?

**CHAIR**—I am very happy for somebody to take this up, but I also have Mr Kidd waiting to give a reply to an earlier question. Could you hold that, Mr Kidd, and I will ask people if they would like to comment on Senator Lees's question first and then it is over to you, Mr Kidd. Does anyone know or want to talk about something happening in schools?

**Ms Kirk**—The ACT government does have a vocational program for their students in that they actively look at careers and try to facilitate work experience to take them down that career path. We actually take students—

**CHAIR**—At what age?

**Ms Kirk**—At 17 or 18. In years 11 and 12 we take them, due to the nature of the work that we are doing.

**CHAIR**—Mr Kidd, do you wish to make a contribution regarding Senator Knowles's earlier question?

**Mr Kidd**—Industry now sits passively on the end of the supply chain. Previously, industry controlled both production and outputs in terms of graduates. In 1984, with the transition to the tertiary sector, that changed. There were lots of promises made. Largely, industry has been on the receiving end of the production line. That is just one point I would like to make. Nursing has diversified very much like medicine has. In fact, there are so many niche areas that now exist that there is no shortage of areas in which you can specialise. In fact, there is an expectation that that specialisation is supported through additional qualifications.

In terms of the way in which the industry structures itself, there was a period when staff did not self-select; they were selected. So now you have graduates able to self-select as to what they choose to do, and those areas that were never remarkable, in the sense of attraction anyway, remain more unremarkable. The mental health area in which I work has an additional problem whereby in order to work in that area in the Territory you have to have an additional qualification. So in trying to attract people in the first place we then have that added issue.

There was always a high attrition rate with student nurses in hospital programs, so many of the things that are attributed to the transfer to the tertiary sector are being ignored. If it was possible, if they were kept and you were to look at the past failure rates with some schools, better than 50 per cent attrition had been achieved by the time people got into their third year. Added to that, where you have a mobile group between 18 and 22, they often like to travel. So in the sense that the world is your oyster and you can be paid three times what you would be paid in Australia to work in the UK, there are all sorts of attractions.

**CHAIR**—Have you got those figures? We have heard claims that you get better money for being a nurse in the UK, but we have not heard that it is three times as much. Can you provide us with any evidence of that?

**Mr Kidd**—It is simply on the basis of the exchange rate. I know of a lady who used to be a director of nursing who has gone to the UK and who is working at the level of a charge nurse and earning more than she earned in Australia. She manages to send X amount of her salary home and she has no intention of coming back.

Work conditions over there are worse—much worse, by all reports. But that is another land. Nearer to home, we have faced that issue of how you attract people to work in mental health. We have an access problem; we have to access graduates in the first place. The propaganda, if I could term it that, that is used to guide people in terms of their career choice is towards those technology based areas. I have interviewed people who have told me that they are leaving mental health to go back to real nursing because they have been told they have wasted their graduate year in a mental health setting and they have been told elsewhere that they have wasted that year and they would have to start again.

**Senator KNOWLES**—Can I just come back to what Senator Lees was asking. If this is a real problem with scores going down and that is why we have more people, there is a double question—and I think this is what Senator Lees was asking—of attracting schoolgirls but also schoolboys into nursing. Men make great nurses, too. I notice in your submissions that you talk about it being a predominantly female profession. It is, but there is no reason why it should be.

**Mr Kidd**—Five per cent of nurses are men and they make good nurses, it is said….

**Ms McDonald**—The other five are pretty hopeless, are you saying?

**Senator LEES**—The other five are what?

**Ms McDonald**—He is suggesting that they are no good—the other five!

**Ms Kirk**—It is interesting, because I think men make up five per cent to 10 per cent of the profession and 65 per cent of the senior positions.

**Senator KNOWLES**—Is that right?

**Ms Kirk**—They do, so the constraints for women really need to be taken on board.

**Senator KNOWLES**—That is fortunately beyond our ability—

**Ms Kirk**—It informs where the education dollar in the household can go, where the energy in the house can go, to promote someone's career. It is reflective of our society.

**Senator KNOWLES**—Let us come back to Senator Lees's question: how do we get more young men and women with higher scores opting for nursing higher up the scale than opting for something else and nursing being the position of last resort?

**Mr Kidd**—If you have an entry requirement of, say, 75 into nursing—and I will take, if I can, a personal situation. My own daughter has elected to do a commerce/IT degree at the ANU. Nursing has never entered her head, not because of any home based dissuasion but simply because of the choices in terms of life choices. People are much more aware than when I was 18 about what to do with their life and where to go to get it. We struggle with offering all the things that society these days is not necessarily fond of.

The family-friendly workplace issue haunts us on a daily basis in that we change enterprise bargaining agreements and awards to accommodate those sorts of family-friendly workplaces. If you have done any rostering in any setting and you then accommodated all those requests, you find yourself in a worse position; some people are happy but overall there are fewer of you to go around. Permanent part-time work is a great option, particularly for people who have differing needs or are at differing points in their life, whether they are having children or moving into a different phase, but it creates major difficulties. If a full-time person goes part time and they go to three days a week, you have lost the other two days and you were already short before it happened.

**Senator McLUCAS**—I just want to follow up the points you made earlier, Ms Kirk, about the fact that nursing is female dominated and then the point you made subsequently that 65 per cent of the senior positions are held by men. Do you have any recommendations about what strategies could be adopted to encourage women into those senior positions? That also goes to another point you made earlier about nurses being managed by non-nurses. Could you extrapolate on that?

**Ms Kirk**—The first question is: why aren't women more fairly represented in senior roles? I think we would have to go back and look at the fact that most women hold dual-role responsibilities. They have a career as well as, at the end of the day, being primary carers in the household in our society, by and large. There is the odd exception, but by and large they carry that. So at the time in their career when potentially they should be able to make their mark, they are, in fact, working part time while raising a family. Somehow or other, we need to look at

structures that allow for them to progress in their careers while not necessarily being available full time in the workplace.

We are quite inflexible about senior positions and the time that people must be available to hold those senior positions, as in full time. That is the reality for them. So until their children are no longer so dependent on them, they are not available for the senior positions. It is a structural change and a mind set in our systems about how best to realise the full potential of our work force—of all of our work force. That is one part of the question. Can you remind me about the second part.

**Senator McLUCAS**—The second part is partially related. It is about the point that you made earlier in your first submission about managers in nursing often being non-nurses. People who are telling you how to do your job are not necessarily trained as nurses.

**Ms Kirk**—We are slipping into an area of changed organisational structures and lots of anti-hierarchy approaches. No matter what sort of structure we have, we have a hierarchy. Whether we like to admit it or not, there is always a hierarchy. But in those changed structures, professional groups find themselves no longer responsible for their own professional work. They have line responsibility to people outside their professions.

The evidence both nationally and internationally when we explored this issue—because this was something that came out of the focus group—shows that those organisations that have nursing with a strong sense of purpose and have legitimate authority over the business of nursing are, in fact, magnet organisations. They do attract staff, they do retain staff and they are known for their quality. So we would say that there is good evidence to support the profession being responsible for its own business, and to itself, to an organisation, to achieve the best for an organisation.

**Senator McLUCAS**—What proportion of managers—it is not a profession I understand; I am a teacher, not a nurse—in the sector are not nursing trained? Could you give me a feel for that?

**Ms McQuellin**—That varies enormously, even within the same organisation, because you can have, because of managerial structures that have been implemented, a generic management position with direct line authority to nursing—even in the same organisation, a different structure, where the line management is to a nurse manager. So there is quite clearly potential conflict in relation to legitimate authority and decision making over standards and issues related to clinical decision making, which clearly are the domain of a discipline which is legislated around its practice as against a generic manager, who may have very good managerial skills but because of the structure in which they work they are authorised, because of that structure, to have decision making over all issues. It is not tenable, and it is a structure that is gradually creeping in, I suppose, to a lot of health service areas. It is not about generic managers per se, but it is about nursing having legitimate authority over clinical decision making at every point.

**CHAIR**—Can I ask whether the other groups would like to add anything further to that question.

**Mr Kidd**—The national mental health standards require that all positions in the mental health service be open to all disciplines. So, in a sense, there is a national standard that requires that when you advertise a position in a community mental health team, it has to be open to a nurse, an occupational therapist, a social worker, a psychologist or a medical practitioner. It is argued that nurses tend to carry the day, because there are so many of them. But where nurses cannot be found—and there are jurisdictions where this is the case, and I made mention of this in my opening remarks to you—nurses have simply been passed over. Where they are absent and they do not exist, they are replaced and they are no longer thought about in terms of it being too hard to get them. There are quite a number of social welfare graduates that come out of universities—many more of them than nurses—and all of whom are available. They are finding their way into this. What is happening is that these teams are suffering because there are skills that nurses have that are not available to those teams any more. But again, there is little that the industry can do to regain the ground.

The other thing that I would say—and it was mentioned earlier, I think—is that there has been a wholesale decimation of promotional positions for nurses within its own industry. Primarily, these days, that is a source of frustration for people who are looking for a career path when so many of them have been lost.

**Ms McDonald**—While I agree with the issues about nursing reporting to nursing, I think it is also important to recognise that nurses are part of a health care team. I think what has happened is that we have got more and more multidisciplinary teams and some of those teams are being managed by the non-nurses. In some parts of our organisation, we have got nurses and nurse coordinators who take away that line management. But it is also important to recognise that nurses have a lot to contribute to the teams. I think that more and more we have to think about a teams approach to health.

**CHAIR**—I think all of you seem to agree that there is a nursing shortage. Can you give us a figure?

**Mr Kidd**—I can give you a break-even. Last year we engaged as many as we separated.

**CHAIR**—Are we talking about a shortage, a short-of-time in service and a more rapid turnover, or both?

**Ms Booth**—It is about the retention of nurses.

**CHAIR**—As much as anything, it is about retention?

**Ms Kirk**—And succession planning. Our work force is ageing. We have got about eight years on average left in our work force and there are no young ones coming up.

**CHAIR**—I keep hearing that the average age is 44 and it is a very old profession. Some of us are enormously encouraged—

**Ms McDonald**—Our average age is actually older than 44. Our average age is about 49.

**CHAIR**—If you have anything further that you can provide to us, we would be happy to receive it. When we ask for further evidence we do not want a thesis. If you could say, 'In our area, compared to five years ago, we are down by X,' that would be helpful. If you cannot, please do not worry about it. In light of the shortage, do any or all of you use agency nurses?

**Ms Booth**—We do not.

**Mr Kidd**—Yes, we do.

**CHAIR**—Where do you get them from? Is it an ACT agency?

**Mr Kidd**—I cannot tell you where we source them from, but we get them from an agency in the ACT. I cannot tell you the name of it.

**CHAIR**—What is the charge for an agency nurse compared to what you pay for a non-agency nurse?

**Mr Kidd**—At least 10 per cent on top. I could get the figures for you, but at a minimum—

**CHAIR**—We would appreciate that.

**Mr Kidd**—some charge more.

**CHAIR**—You are saying that sometimes it is more than 10 per cent?

**Mr Kidd**—Some charge a premium, depending on where the shortage is and how much of a skill base you are after. You do hear stories of amazing amounts of money being paid to staff neonatal intensive care units, for example.

**CHAIR**—Are you aware of the figures of the Victorian agencies who have been charging $200 to $260 an hour?

**Mr Kidd**—I have read those things in the press, yes.

**CHAIR**—Do you know what percentage of your nurses are agency nurses?

**Mr Kidd**—Very minimal in the mental health area. With respect to the Canberra Hospital proper, I am not in a position to comment on that.

**CHAIR**—We will ask other people about that. Very minimal: are you talking about within an institution or are you talking about mental health nurses outside institutions?

**Mr Kidd**—Here in the Territory, we are talking about specifically the acute psychiatric unit at the Canberra Hospital.

**CHAIR**—Do you have mental health nurses in the community?

**Mr Kidd**—We do.

**CHAIR**—And you are here to tell us about both?

**Mr Kidd**—I represent all mental health nurses working for ACT Mental Health Services.

**CHAIR**—Thank you. Certainly ACT Community Care mentioned more about the interface between universities and the health sector. In about half a minute each, can you tell me what facilities each of you have and raise any concerns you have about better training in relation to the questions you have answered to Senator Lees and Senator Knowles. Do you have a place where you can take those complaints or do you wake up in bed saying, ‘I wish we could talk to someone’?

**Ms McDonald**—We talk regularly to the Canberra university to try to get them to change their courses to accommodate our nurses.

**CHAIR**—Who does?

**Ms McDonald**—Me.

**CHAIR**—In what capacity do you do that?

**Ms McDonald**—As the principal nurse. We talk to the nursing school at the University of Canberra. We have also started talking to the Pro Vice-Chancellor, who is relatively new, so we are hoping to—

**CHAIR**—Have you had any success?

**Ms McDonald**—Not yet, but we are hoping to make better headway.

**CHAIR**—How long have you been talking?

**Ms McDonald**—Two years.

**CHAIR**—I will hear from others before I respond to that.

**Ms Kirk**—I would have to take informal channels to speak to the university.

**CHAIR**—So that means that you might just inadvertently or advertently bump into the nurse educator and say, ‘Listen, we are going off our’—

**Ms Kirk**—I would have to approach somebody specifically. There is not a forum per se for me to use.

**CHAIR**—And there is not a way through the health department?

**Ms Kirk**—No, unless I informally used Heather as well.

**Mr Kidd**—We raise issues through our management structure which goes through the department, which has been very supportive within the resource base that they have available to us to support postgraduate training. We have had discussions with the University of Canberra. We have been able to achieve elected study within the La Trobe program, but the University of Canberra just does not have the critical mass to offer a mental health program locally in terms of the size of its faculty and the specialisation required.

**Senator LEES**—The University of Canberra basically makes its own decisions as to how many nurses it trains. I guess that has to do with its overall level of funding or a particular faculty's ability to negotiate more places in their faculty. Obviously we have to get our questions that we have to ask the university itself, but what is it that would trigger the university's willingness to offer additional places and to offer a commitment?

**Mr Kidd**—Scale.

**Senator LEES**—Meaning what?

**Mr Kidd**—In our case, the uptake of postgraduate programs with the university makes it difficult, if you like, if there is a break-even point between running the program and having enough enrolments. It is the chicken and the egg problem for us. We do not attract enough people to do the course if it is available, so we shop elsewhere. But we are very mindful of trying to retain the University of Canberra within our thinking and our decision making as best we can.

**Ms McDonald**—If we guarantee a certain number of placements they can then provide the course, but then we cannot absolutely guarantee that 20 people from our organisation will do the course.

**CHAIR**—Are you talking about postgraduate here?

**Ms McDonald**—Yes.

**CHAIR**—What about influencing the curriculum content in the undergraduate program so that the points you raised earlier are addressed—that is, people get more than two days in three years out in the community?

**Ms Booth**—Again, we have tried over two years to influence that. I was out at the university this morning addressing second-year students about community nursing. So we try to do that, but there is a lot of inflexibility about the course content. In the first year they do whatever. In the second year they just start their placements. The third year is the final year. So for the first time we have been approached to take a third-year student in their final placement.

**CHAIR**—So you have now discovered in the course of the year to this point that there is a considerable difference from one university to another about how nursing is being taught and how much is being taught within the clinical situation, and that can mean anything except the

university clinical situation. I am just interested in how you tackle talking to the institution. That is a question we need to take up with them. Does the ACT have a chief nurse that you can all ring at any time of the day or night?

**Ms Kirk**—No.

**CHAIR**—Would you recommend this as a good thing?

**Ms Kirk**—Yes.

**Mr Kidd**—Yes.

**CHAIR**—I turn now to pay scales. If you could provide us with any information from your organisations about the pay nurses get in your different areas, that would be helpful, in particular what pay they start at and how the pay increases. We will probably have to do the comparisons with other states ourselves. Is it true that if you get postgraduate qualifications in Canberra it does not necessarily mean one extra cent?

**Ms Kirk**—No.

**CHAIR**—In other words, you all agree with me?

**Ms Kirk**—Yes.

**CHAIR**—Please do not say no when you agree with me. I think that is one of those shocking questions. It is the case that nurses with postgraduate qualifications get no extra pay for that?

**Mr Kidd**—That is correct.

**CHAIR**—Is it also the case that some nurses are on part-time arrangements and they get more money for staying at a lower level because they are on bonuses for extra time? It is probably more acute at hospitals.

**Ms Kirk**—Do you mean doing overtime?

**Mr Kidd**—There is a disincentive to take certain middle management positions. The responsibility rises markedly; the remuneration does not. In New South Wales there was a need three years ago to increase nursing managers' salaries by a quantum of 20 per cent to do something about the problem of people not wishing to relieve or apply for those sorts of positions.

**CHAIR**—We are running out of time, but I want to put at least a couple more questions to you briefly. There was loyalty to an institution all those years ago when nursing was not the same as it is now. People used to say, 'I'm a St Vincent's trained nurse,' or 'I belong to the RPA,' or 'I came out of the Royal Melbourne.' I have not yet heard where the new loyalty is. Do

people say, 'I'm a Canberra university graduate'? Do you think there is any point in brand loyalty, or is that not an issue you have thought about?

**Ms Kirk**—From a marketing perspective, brand loyalty is always useful. In my experience it is not something necessarily that has come from the universities that we experience in Canberra.

**CHAIR**—If people have to go out of Canberra to do their postgraduate training, that seems to me to be a divide in that they do not come back in again, but I think that is the point you were making before. Can any of you comment upon the problem of medications? Do you have any difficulties with people not qualified being the ones who give medications, or is this not a problem in your areas of nursing?

**Ms Kirk**—We have a Webster pack system. So if we have personal carers or relatives giving out medications, they come prepacked by a pharmacist. The GP writes a script to the pharmacist and that is how we manage medications in the community—oral medications, anyway.

**Mr Kidd**—Ideally, we would like to see people manage their own medication and manage their own lives. Where we need to be an adjunct to that it is place and circumstance. If there is another level of worker, that would certainly be objected to in places like hospitals. In a community setting, the best thing that we can do is develop partnerships and confidence in the family. If we can support what is a legally prescribed substance to be given to a person over time, we would prefer that option. But as for untrained people being responsible for the administration of medication, we would object to it.

**CHAIR**—Thank you. I turn to ENs becoming RNs. We have heard that there are lots of ENs who would like to become RNs but there is not a place in any institution that they can get into, although there might be a couple. As an entry into nursing, we have been told that a lot of people are choosing the EN way because it suits them, it is accessible et cetera. However, bridging across to be an RN is a major problem. All of you have nodded. Does that mean that in Canberra that is also a problem?

**Ms McDonald**—In Canberra they have to do the full three years if they want to become a registered nurse, even if they are an enrolled nurse.

**Ms Booth**—Except if they go through Charles Sturt, which is a bridged course, or the Northern Territory. So it means distance education for them.

**CHAIR**—So you are telling me, Ms McDonald, that some of the EN nurses have to then do a full three-year course. There is no recognition of prior learning.

**Ms McDonald**—Not at Canberra university.

**CHAIR**—Not at Canberra. But the other option is that you can be bridged by going to Charles Sturt or Darwin.

**Ms McDonald**—And some of our staff are doing that. Quite a few of our enrolled nurses are actually doing that.

**Ms Booth**—It is a distance education module.

**CHAIR**—In relation to a national strategy, do you think we would be assisted by a national strategy for nursing?

**Ms Kirk**—Yes.

**CHAIR**—Everybody is saying yes. Some of you have mentioned violence against nurses. We have actually been introduced to the extremely curious concept of horizontal violence. That does not puzzle you?

**Ms Kirk**—No.

**CHAIR**—It certainly puzzled those of us on this side of the table.

**Mr Kidd**—That is very well researched and documented.

**CHAIR**—We think it means bullying; is that right?

**Mrs Byrnes**—Absolutely.

**CHAIR**—One nurse on another. And 'nurses eat their own' is another way of describing it. It is a very good profession.

**Ms Kirk**—If you looked at suppressed group behaviour, that is what goes on.

**CHAIR**—And it is not about violence by patients to nurses?

**Ms Kirk**—As well.

**CHAIR**—But that is called vertical violence?

**Ms McDonald**—It is called unacceptable violence.

**CHAIR**—I note that we have had this raised as a very important concern by just about all witnesses. Perhaps Ms Kirk you raised it in particular. Do you think that it is something that is just a work practice or an industrial condition or do you think that it also goes to the culture of institutions?

**Ms Kirk**—I think that it is as complex as that. To say that it is one single thing would be naive. It is a complexity of issues.

**CHAIR**—And finally, Mr Kidd, are nurses an industry or a profession?

**Mr Kidd**—I think nurses are learning to be a profession.

**CHAIR**—Florence Nightingale would be shocked to hear that. That is interesting. Are you saying that they are only becoming a profession?

**Mr Kidd**—I think that we are learning in terms of maturing from an apprenticed approach only as recently as the early 1980s. It takes time to grow accustomed to the way in which a profession conducts itself. We do not tend as a group to be very strategic in terms of how we operate. We tend to defer to industrial bodies. The colleges in terms of their influence are somewhat obtundent because of their access—for example, the absence of a chief nurse in Australia. So in terms of strategic clout, if I could use that expression, nurses find that an easier way to get what they need is to turn to an industrial body to get it. I think that industrial bodies do an excellent job, but I would still say that we are learning how to be a profession.

**CHAIR**—Thank you. We have gone over time. We very much appreciate your submission and your coming today.

[4.37 p.m.]

**KILLION, Ms Susan, Executive Director, Health Strategy and Acute Services, ACT Department of Health and Community Care**

**MAHER, Mrs Rhonda, Associate Director of Nursing, Calvary, Calvary Health Care ACT and ACT Department of Health and Community Care**

**SCOTT, Ms Joan, Manager, Workforce Unit, Health Policy and Reform Group, Health Strategy and Acute Services, ACT Department of Health and Community Care**

**MOWBRAY, Ms Donna, Senior Nurse Adviser, Canberra Hospital, ACT Government**

**O'KEEFFE, Mrs Ellen, Elected Member, Nurses Board of the ACT**

**PARKE, Ms Jill Maree, Board Member, Nurses Board of the ACT**

**CHAIR**—I welcome representatives from the ACT Department of Health and Community Care and the Nurses Board of the ACT. The committee prefers all evidence to be heard in public, but if you wish to give your evidence or some of your evidence in camera you may ask to do so and the committee will give consideration to your request. The committee has before it your submissions Nos 937 and 444. Do you wish to make any alterations to those submissions?

**Ms Killion**—No.

**CHAIR**—I now invite each group to make a brief opening statement and then field questions. Maybe we should hear from the Department of Health and Community Care first.

**Ms Killion**—Thank you. The ACT government supports this inquiry. While acknowledging it has a key role to play locally, it views as critical the establishment of a national strategy. While acknowledging the importance of addressing coalface issues, such as occupational health and safety and family friendly workplaces, a national strategy must involve a comprehensive intersectorial approach that recognises the unique characteristics of our current nursing work force, current and emerging health care models and their subsequent demands, and the needs of current and emerging labour market participants.

As background, this nursing shortage is really a symptom of a larger problem that is haunting our society at the moment. Like anyone with symptoms that are painful and prevent us from functioning well, these are brought on partially of our own making and partially because of the environment in which we live. It is important that we identify more than symptoms—in this case, unfilled nursing positions and an inability to attract and retain nurses—we need to go to the core, to the very cause of the problem and look for solutions to these as well. If we do not do this, we will be back here facing another inquiry in two years or five years, with the same problems that have not gone away.

While we are grateful that this inquiry and the review into nursing education are occurring, as these are the first steps towards acknowledging the problem and trying to measure its extent, we

in the ACT would suggest that this inquiry must go further than symptom identification and management. It must identify that society and its values have created the environment in which this problem has been allowed to grow unrecognised to the point of crisis.

It is no coincidence that this problem is in a female dominated profession. It is also no coincidence that the aged care, mental health and community care sectors are the hardest hit. These problems are merely the reflection of our society's values. Clearly, our values are centred around technology: medical technology, surgical technology, information and pharmaceutical technology. They are not centred around caring. This is where we invest. We invest in these technologies; we invest in a business-oriented cure-focused area of health. We have allowed the imbalance between cure and care to swing out so far that we are in crisis. In our society, we have proven that we are very good at saving lives but we are not good at supporting the living.

I mentioned that, like many symptoms of ill health, this crisis is partially of our own making. We have not planned the caring professions. By these I do not just mean nursing, although that is our focus today, but all of the caring professions in which there are shortages. We have not kept pace with the changing needs of our present and emerging labour market. We—and by that I mean the Commonwealth and state departments of health, the health care sector providers, educators and unions—have not been proactive in providing a workplace that is responsive to the demands of the current work force, let alone the upcoming generations of our work force. We have not had a vision for a health work force. We have tried to make the work force fit into our organisations—some of which are anachronistic—rather than designing our systems to answer the needs of our people, including our caring work force.

On behalf of the ACT, we have provided a written submission about the nature of our work force and the initiatives that we have put in place to address other local problems. I will just summarise these, knowing that you have them in front of you and you have heard them all before. We will end by presenting some recommendations to the Senate inquiry that will hopefully address these larger problems—the core problems—to which I have just alluded.

Certainly, the key points that the ACT government have raised in terms of the situation that faces us today is that we do have separation rates, exceeding 25 per cent over the last three years in the territory. The territory is experiencing a shortage of appropriately qualified nurses. The average age of the ACT nursing work force is 45-plus years. The number of nurses leaving the work force over the next few years will increase exponentially. This is part of the environment in which we are all the baby boomers, and we have this demographic that we just have to deal with. The nature and magnitude of the situation across Australia is such that a nationally coordinated approach involving the health care and tertiary education sectors and others must be agreed and implemented as a matter of urgency.

With no clear rigorous and nationally agreed methodology available, there is widespread concern that it is not possible to accurately determine and report on the actual number of nursing vacancies, either locally or nationally. We have talked about the gender base of the nursing work force. That is a real issue. The current funding models in aged care generate very specific work force issues around supply, demand and the quality of nursing care delivered. The ACT enjoys a high demand for entry into undergraduate nursing courses—usually twice the

number of the places that are made available—and a low demand for entry into re-entry refresher courses. I think Community Care may have covered some of those reasons.

In summary, the ACT government believes strongly that a strategic intersectorial solution must be implemented if a way forward is to be found and recommends the following. The first of these recommendations includes that the Commonwealth undertakes extensive strategic planning related to the nursing work force and its unique characteristics based on solid ongoing research. We note that AMWAC has been funded for a multitude of years. This research should also include the determination of a national information management system that will allow for accurate monitoring of the nursing work force. We also recommend that the Commonwealth, in collaboration with national nursing organisations, implements a major national marketing campaign that is aimed at raising the professional profile of all nurses in nursing. In addition, a separate but linked marketing strategy must be directed towards the stigmatised areas of mental health and aged care. The reason you cannot attract nurses to go into those areas is because nurses are just part of the society, and the society does not value that part of our society.

We recommend that the Commonwealth makes a dedicated investment in addressing long-term planning by the funding of a chief nurse directorate—and by this we mean a directorate, a group of people, not a single individual—who will have responsibility for work force, education and other professional issues and will work in collaboration with state and territory branches. Finally, we recommend that the Commonwealth and states work together towards some convergence of health and education policies to allow for greater flexibility in the funding of education places consistent with the work force requirements and to provide relevant incentives, such as HECS subsidisations on all nursing education.

**CHAIR**—Thank you.

**Mrs O'Keeffe**—Thank you for this opportunity. We appreciate the recognition that this inquiry is giving to the national problem in the nursing profession. There has been a decrease in the number of nurses practising since 1980, but this decrease is not necessarily reflected in the number of nurses registered. There is an experienced shortage of practising nurses while sometimes there is not an actual shortage. Therefore, with the worsening shortage, if it is to be rectified we need to investigate other issues which impact on why nurses are not practising.

There are many underlying causes of the nursing shortage which I am sure everyone else has alluded to today: the steep growth in the demand for health services; a diminishing supply of new students, both in undergraduate and postgraduate education; an ageing work force; and a baby boom bubble that will require intensive health care services in the future. There is also a broadening of job opportunities, both within the health profession and for females in general. There is a reduced opportunity for career progression in the nursing profession. There is a lack of support for ongoing professional development. We actually have a female dominated profession, with the competing demands of career and family responsibilities. There are significant strategic changes in the allocation and distribution of health resources, which have an impact on both the nursing shortage and the areas where we do our business.

Traditionally, nursing care was undertaken in hospitals. More importantly, these days it is undertaken in the community. We need to put the focus into the contemporary health care

context. In this we need to consider that there has been downsizing and restructuring of health services. There is an increased patient acuity. In hospitals we are now seeing patients nursed on wards whereas they were traditionally nursed in intensive care areas. We have a contribution to the health care product as opposed to the allocation of resources, and we have a comparative work issue of where the resources are placed—whether they are placed into nursing or other industries and professions. I would not like to suggest strategies to address these. You need to understand that the issue is that we train people and they do not practise, as well as that we cannot recruit people into training courses—although that is not the case in the ACT.

We need to have organisational structures that support authority and responsibility. The organisational structures need to be redesigned both in a collaborative way for management and at delivery level—a shared government model that increases cross-stream communication and actually puts the person receiving the care at the centre of that focus. Such structures would be in a practice environment with care models and defined nursing roles which give nurses autonomy over their practice and enable them to undertake their practice in an environment that empowers them. If we are to attract young people—both men and women—and those from culturally diverse backgrounds to the nursing profession, it needs to be a self-governing, self-determining profession that can utilise resources to the benefit of the people it provides care to.

We need to develop career structures. We need to develop meaningful pathways that provide recognition of the contribution of nursing care to health. This is evidenced by the lack of nurses' ability to cope in a changing environment, management's lack of commitment to ongoing education, and the continual reduction in the provision of resources for nursing.

In relation to remuneration, nurses' work is often seen as synonymous with women's work and has been underpaid and undervalued for too long. It is often stated that the way you view your nurses is the way you view your women in society. We cannot sustain current practice standards without improvement in salaries and remuneration comparative with skills and knowledge. Nursing per se is one of the most underpaid professions. Currently, in the ACT structure, a level 1 nurse gets paid the equivalent salary of an ASO3 clerical person who has no skills or qualifications.

**CHAIR**—What is that amount?

**Mrs O'Keeffe**—I think that it is around $34,000. The ASO3 structure is $34,000 and the level 1 nurse is $34,000.

**Senator KNOWLES**—What is the level 1?

**Mrs O'Keeffe**—A level 1 nurse is a new graduate nurse, with a minimum of one to eight years experience. It is an entry level position. There actually needs to be a strategic response on the part of all governments and professionals within the nursing profession to alter the image of nursing. We need to market our image. We need to say what the profession achieves. We need this to have recruitment of people and to attract existing persons back into the work force. Nursing needs to be repositioned within the structures. It needs to be repositioned to give value to the contribution it makes and to the highly versatile nature of its work through science, technology, care, critical thinking and decision making.

Continuing education needs to be reviewed. Health care in Australia is dynamic. It is challenging. Nurses need opportunities to stay current. They need to remain competent, and they need to alter their scopes of practice to meet varying needs. Education is the cornerstone of professional development, and we must minimise the barriers to this education. Within the nursing profession, nursing education is often at the expense of the individual for the good of the community. We need to have the ability to make a strategic contribution to health policy planning. At the moment nursing is not represented in any Commonwealth department or state department at a strategic level. Without that input, the nursing voice is not recognised and the nursing contribution to health care is not accounted for.

With respect to research and development, there actually needs to be political motivation to have research into nursing to define the outcomes and evaluate the nursing contribution to health care. We also need to evaluate the effects of the nursing shortage on the preparation of the next generation of clinical nurses and also on the effect it will have on ongoing care. It has been demonstrated in many research undertakings that a high level of nursing care contributes to good patient outcomes, poor level of nursing care or the unpaid unqualified worker actually contributes to adverse events and adverse outcomes for patients.

We need to make the profession women friendly. Nursing is a female dominated profession and, even though gentlemen have been training to be nurses for 30-odd years, that percentage has not changed. We also need to understand that nurses have a dual role and responsibility in our society. The average age is mid-40s, and those women are actually rearing children—and in this day and age more often in a single parent family—and taking responsibility for caring for the elderly in the form of their parents. This puts conflicting demands on the female in her working role, and it is very difficult sometimes to demarcate the home role and the professional role. The profession needs to be more focused on being female friendly to retain those people in the work force.

We also need to value the profession. Nursing has a unique role to play in health care. It is often the first point of contact for many patients in the health care scenario, but unfortunately they often do not have a say in the care provided to patients. They often work in conflicting environments and conflicting ethical situations. That creates conflict, and people do not work in that situation.

There are also some particular occupational health and safety issues that need to be addressed. One that has already been discussed is violence. I think we need to do research into workplace staffing levels and skills and the effect that has on oppressed group behaviour and the actual horizontal violence that is in the workplace. We need to look at safety standards and environmentally friendly strategies; that is, work patterning, safe staffing levels and safe hours of work. Thank you for giving me the opportunity to speak to the committee.

**Senator KNOWLES**—I think some of you were here earlier when I was talking about trying to attract more people into the profession to start with, and I might direct these questions to the board. What role, if any, does the board have in career guidance in schools?

**Ms Parke**—It has none.

**Senator KNOWLES**—Is there any good reason why? Have you been given a reason why? Have you asked whether you have a role?

**Ms Parke**—The Nurses Board has one clerical staff member attached to it at present. At present we are in between directors of what you would call the board and all the board members are volunteers, so board work is done in our own time, if there is any. As for being able to go out and market ourselves in the schools to attract people into nursing, I am not sure whether our employers would be all that keen on us using more of their time to go and do the marketing. In the ACT we do not have the resources available to do that type of marketing yet. It is something we would like to do and we plan to look at doing. We have put that into our strategic plan. For this particular board at the moment, it has been recognised that one of the ways to achieve people coming in is to get out and market nursing within school settings, but it is not done at present.

**Senator KNOWLES**—Is anyone having any contact or influence with those who are running the career guidance courses and advice at schools?

**Mrs O'Keeffe**—Not from a board perspective on a formal level. Members of the board do sit in the educational institutions in town and do have some influence there.

**Senator KNOWLES**—Is there any other organisation that would be able to do such a thing on your behalf; that is, go and see career guidance officers?

**Ms Parke**—The Royal College of Nursing actually mans career expos around Australia, but there is no ACT body that actually does that.

**Senator KNOWLES**—That might be terrific and desirable, but I think you would probably agree that the drip system also works as opposed to someone just walking past a booth and saying, 'Ah, I see the light. I'm going to be a nurse.'

**Ms Parke**—There are certain things that used to be done that are no longer done by various governments. One example was a scholarship to get into nursing and things like that. If there were any way in which, either federally or state or both, this could be re-implemented—it used to be called the old bursaries or something, I believe. There used to be a system of scholarships for people going from secondary school into professions. That was many years ago, and those scholarships are no longer supplied. That could be a way of attracting people in, if they knew that there were scholarships available to actually undertake their nursing education. That was one way of attracting quite a few people to the profession. So there are ways that are available, but I do not think anything is achieved unless there is commitment by both resources of the people and the financial resources.

**Senator KNOWLES**—Does the government have any particular programs that you really focus on in schools to attract the smart young men and women who really would look at nursing as an option—look at all of the options within nursing as opposed to just going and being a nurse?

**Ms Killion**—No, we do not have a program like that at the moment.

**Senator KNOWLES**—Is there any reason why not? Is it too hard? Is it lack of input from the profession? Is there any other tangible reason other than saying, 'Well, we haven't thought of it'?

**Ms Killion**—I think the latter.

**Senator KNOWLES**—Is there any prohibition to doing it?

**Ms Killion**—No.

**Senator KNOWLES**—How difficult would it be to put something constructive together about nursing into—

**Ms Killion**—Not difficult.

**Senator KNOWLES**—How would you go about it, just as a thumbnail sketch?

**Ms Killion**—This is part of our approach where we were saying that we needed a strategic intersectorial approach. Certainly, talking to, and working with, the department of education is the first step. We need to try to promote the role that way. That is a very good strategy.

**Ms Mowbray**—If I may just make a comment on Canberra Hospital's point of view. We have discussed the possibility of going into schools. I think what has happened is that, when the education of nurses moved from hospitals to universities, we did not think strategically. There has been a gap in getting out and talking to school leavers. There are work force expos where we are already speaking to undergraduate students, but that is too late. We need to move on getting into schools at years 9 and 10 at the latest. So it is in a developmental stage at the moment.

**CHAIR**—When you say 'we', are you telling Ms Killion that this is a good thing for her to pick up or is this 'we' a different we? Are you speaking here on behalf of the government in answer to Senator Knowles's question?

**Senator KNOWLES**—Or specifically the Canberra Hospital?

**Ms Mowbray**—My response was—

**Senator KNOWLES**—Linking it together.

**Ms Mowbray**—Yes.

**Senator KNOWLES**—I was going to ask you another question, but it has just gone completely out of my mind.

**Senator LEES**—I will jump in.

**CHAIR**—Senator Knowles, if it comes back, please just call out and you can put your question.

**Senator LEES**—I want to go back to the role of government in the picture of the nursing work force. Do you do monitoring of how many nurses you have—that is, how many enrolled nurses and how many registered nurses—and some sort of rough, overall view of where they are working?

**Ms Killion**—We do have some monitoring capacity. We do know how many registered nurses and enrolled nurses there are. We do know who is in the community care sector and in the hospitals as well. So there is some monitoring role there, yes.

**Senator LEES**—Could you give us a picture of shortages in terms of roughly where—

**Ms Killion**—Roughly, yes.

**Senator LEES**—Not now, but if you could take that on notice—

**Ms Killion**—I can tell you now what I know. I do not know about community care shortages per se, but certainly in one of our hospitals we have a four per cent vacancy rate.

**Senator LEES**—And that is fairly constant? That is ongoing?

**Ms Killion**—Yes. In the other, we have a 12 per cent vacancy rate.

**CHAIR**—Which is which?

**Ms Killion**—These are the two public hospitals.

**CHAIR**—Which one has got four per cent and which one has got 12 per cent?

**Ms Killion**—The Canberra Hospital has four per cent and Calvary Hospital has 12 per cent.

**Senator LEES**—In terms of filling these, are you looking at a strategy of working with the hospitals, with the previous groups—community health, mental health, specialist nurses—to actually develop strategies that may include, for example, the hospitals looking at what works by way of rostering? In some states I have come across rosters of 12 hours that have been trialled and found successful and very short-term rosters. I am also working with freehold nursing homes to look at various ways of supporting the work force so that they find it more possible, particularly some of those women with other responsibilities, to keep nursing.

**Ms Killion**—We have a newly formed work force unit within the department. Our circumstances are that the hospitals and the ACT Community Care have been working pretty much in isolation. We are in the process of trying to pull that together so that we can have a strategy that is ACT wide. In terms of dealing with the nursing homes, we have not had any work force input into the nursing homes sector.

**Senator LEES**—I realise it is Commonwealth funded, but in terms of actually getting the nurses in on the ground, is it part of your planning to link them in as well so they will be part of it?

**Ms Killion**—Yes.

**Senator LEES**—For all of the nursing body what are support services such as child care like in the ACT? Do you have 24-hour child care that is readily available for those who wish to work shiftwork?

**Ms Killion**—Not across the government. Individual organisations may have such capacity. I am not aware of one that is government subsidised.

**Senator LEES**—I am not asking for government subsidy. I am looking for what is actually available. Have you done any sort of an overview in the ACT—talking to nurses, whether it is in aged care, hospitals or wherever—to try to get some idea or some handle on why we have this huge separation, why so many nurses are deciding it is all too difficult? Or perhaps hospital based?

**Ms Scott**—There are child-care facilities basically on the campus of the Canberra Hospital. A number of years ago and probably—

**Ms Killion**—And Calvary Hospital as well.

**Ms Scott**—And Calvary Hospital. A number of years ago—I know on two occasions since I have been in the system for 20 years we have actually surveyed the nurses and said, 'If there were 24-hour child care would you take your children to that centre?' We did not get enough people who would actually take that up, mainly because they had to pick up their kids at 10 or 11 o'clock at night—wake them up to take them home.

**CHAIR**—Wake them up to take them to the child-care centre.

**Ms Scott**—Exactly.

**Senator LEES**—This is where the flexible rosters come in. The hospitals—and I recently spent time in one in South Australia—are looking at between four-hour and 12-hour shifts to cover those sorts of issues. I am just wondering about what sort of work force planning has been done within the ACT by either the government or the hospitals to look at the options. Can you add anything to that?

**Ms Mowbray**—Yes. From the hospital we have recently completed a trial in intensive care of banking of hours. That allows some flexibility with rostering. Basically you work when the work is there and you bank your hours so that when it is not you can be flexed off, so to speak. We are trialling 12-hour shifts in theatres. It has not gone out into the wards yet, but we are in the process of developing models that we can present both to the staff and to the industrial body to trial that.

**CHAIR**—I just have to interrupt for one minute. Have you got any measurement of the acuity of nurses who work 12-hour shifts who, 10 hours in, suddenly hand the surgeon the wrong instrument?

**Ms Mowbray**—No.

**CHAIR**—No evidence of this?

**Ms Mowbray**—No evidence.

**CHAIR**—Is there any evidence that 12-hour shifts are as productive as eight-hour shifts or any evidence against it? Forget about family friendly or skipping off to the theatre at night.

**Ms Mowbray**—No. Twelve-hour shifts certainly in my experience are in trial mode only. I do not have evidence from experience.

**Ms Killion**—May I just add that there is considerable resistance among the industrial bodies for these flexible working hours, whether they are long or short. Within our industrial relations and our EBAs there are restrictions about that. Whilst that does not mean that we cannot consider it and that we are not looking at it, there are those constraints.

**Senator LEES**—I will jump a couple of questions and go to your submission where it relates to incentives to attract and retain nurses, and you look at wage increases, scholarships, et cetera. You say of these incentives that the package was basically either only partly acceptable or not acceptable at all. What is the reason for that? Can anyone help with why the packages that you developed to try to retain nurses were not implemented in the territory? Of the two public hospitals in the ACT, basically only parts of the practice were accepted in one and there was rejection of the package in the other hospital. What is the impediment there?

**Ms Killion**—That was clearly an industrial objection from one hospital. Both hospitals have separate enterprise bargaining agreements. Under one it was accepted in one hospital and under the other it was not accepted. Subsequent to this submission, however, those industrial arrangements at the Canberra Hospital have been resolved and there is widespread taking up of this pattern.

**Senator LEES**—I am just trying to get at what the sticking points were for our future reference in terms of what nurses are comfortable with and obviously things that are simply not going to be acceptable to them.

**Ms Killion**—Certainly scholarships are very acceptable, and people are taking that up very readily. Area bonuses for areas of need have not been accepted widely because there is a perception that that is discriminating against other areas which are not designated as areas of need.

**Senator LEES**—That is what I was looking for. That helps. Very quickly, you also mention in your submission that re-entry is not being taken up very much at all. Can you give me any

possible reasons for that? Just looking at your turnover, you must have a lot of qualified men and women out there. What is blocking their interest in re-entry?

**Ms Killion**—I think that the re-entry opportunities that we have in the ACT are fairly limited. If we do not have the numbers for a particular program, the university does not run it. I think we need to be more flexible in the types of re-entry programs that we can offer to people. I think the point that ACT Community Care made in terms of trying to fit square pegs into round holes all the time is a valid point. We should have more flexible programs.

**Senator LEES**—Are you looking at re-entry courses, say, for aged care or for a specific area in the hospital, or is it just a generic?

**Ms Killion**—It is a generic re-entry course that is currently offered, but I think we can be more flexible in what we are offering.

**CHAIR**—Offered where?

**Ms Killion**—At the University of Canberra.

**CHAIR**—Have you offered any, or has any thought been given to offering them at the hospital or any institutions?

**Ms Killion**—Yes. Calvary Hospital has a re-entry program as well.

**Mrs Maher**—Calvary has also developed in collaboration with TRACHS, which is a community training agency, a re-entry program for aged care workers, but there is no funding for it. So we have not been able to get that off the ground.

**Senator LEES**—That is not running well?

**Mrs Maher**—It has not started. It is ready to go, it is accredited, it has been approved by the Nurses Registration Board—but there is no funding.

**CHAIR**—Can I just add to that, Senator Lees, and I will go back to you. In Victoria we got figures that there was something like 70,000 registered nurses in Victoria and 50,000 working, which made it fairly clear there are 20,000 people keeping up their registration and doing nothing about it. Do you have that picture in Canberra?

**Mrs Maher**—Yes, we do.

**Mrs O'Keeffe**—Yes, we do. We have approximately 4,000 nurses on the registration list and about 2,100 practising.

**CHAIR**—So you can take these figures away and think, 'Whacko! We are going to go and find them.'

**Mrs O'Keeffe**—In considering that, you also need to consider that some people will sit on many registers and they might practise in New South Wales but be registered in the ACT. So there is some overlap in that.

**Senator LEES**—They might be out at Queanbeyan, for example.

**Mrs O'Keeffe**—Yes.

**CHAIR**—Do you have any idea?

**Mrs O'Keeffe**—No, I do not. I am sorry.

**CHAIR**—Can your registration board ring up the New South Wales registration board and compare how many people are registered in both?

**Mrs O'Keeffe**—I am sure we could if we did that, yes. We could probably find that out by amalgamating the lists and then do a search on them. I am not sure how, but anything is possible.

**CHAIR**—Is it all a database now?

**Mrs O'Keeffe**—Ours is databased and New South Wales is databased but I do not know about the other states. Victoria's is, Queensland's is, yes.

**CHAIR**—That is a very interesting point.

**Senator LEES**—I have one last question. Unfortunately, I think I have to go down to the chamber shortly. We heard other comments before that there seems to be a difficulty at Canberra University by way of how many places they actually have. Has the department been able to have any discussions or any correspondence or communications with them as far as encouragement to increase the number of nurses in courses as opposed to another faculty?

**Ms Killion**—We have not had that correspondence. We have had informal discussions with them. They are bound by their funding levels and the number of places that they are allowed to bill.

**Senator LEES**—So they are not allowed to have more nurses?

**Ms Killion**—That is my understanding. It is unfortunate they are not here. I do not want to answer on their behalf. But that is my understanding.

**Senator LEES**—We are drawing up a list of questions for them so we will add that one.

**Senator KNOWLES**—It is quite appropriate, I suppose, that I have lost the plot on the question that I was going to ask because it was actually about age. All of the evidence that we have—and you are saying the same thing—is that the average age of nurses is now approaching

the dreaded 50. In relation to recruitment or career guidance, how quickly could something like that be cranked up and how quickly would we start seeing results, hopefully, in terms of getting more people into nursing?

**Ms Killion**—If we invested in nursing and nursing education heavily, I think that would crank up rather quickly.

**Senator KNOWLES**—Being 12 months, two years, three years?

**Ms Killion**—A couple of years.

**Senator KNOWLES**—So we would start to see the results with nurses graduating five or six years down the track; is that right?

**Ms Killion**—Roughly, yes.

**Senator KNOWLES**—So there is still a fair bit of gap to be made up?

**Mrs O'Keeffe**—Training is only one issue. You can train as many people as you need; if you cannot retain them you have got just as big a problem. You are actually wasting the money that you put into training if you cannot retain.

**Senator KNOWLES**—True.

**Mrs O'Keeffe**—That is one of our big issues.

**Senator McLUCAS**—I have one question that follows from Senator Lees's earlier questions about the number of registered nurses you have who are not working in the profession. Do we have any data on what they are actually doing?

**Mrs O'Keeffe**—You could look at this table. I think every person sitting behind this table is a nurse and only one person is actually working in a clinical role.

**Senator McLUCAS**—I see. According to your submission, Ms Killion, there are, from my understanding, about 1,400 registered nurses who are not employed in the profession. Are they parenting? Have they moved into another career? Do you know that?

**Ms Parke**—When sending out our registrations last year, we attached a work force planning survey to it and we got a 100 per cent return, which was quite good. But that data has not been collated as yet and has not been fed back to the nurses board.

**Ms Killion**—It is reported through the AIHW. Those are two-yearly surveys.

**Senator McLUCAS**—So we could get that data?

**Ms Killion**—Yes.

**CHAIR**—How long has this work force unit been established?

**Ms Killion**—A few months.

**CHAIR**—So it is all a bit exciting?

**Ms Killion**—A bit daunting.

**CHAIR**—And a bit daunting, too. We have had a number of people suggest that it would be a very good thing in each government—federal, state and territory—to have a chief nurse. Are you of that view?

**Ms Killion**—Yes.

**CHAIR**—You do not have one yet?

**Ms Killion**—We have got a person who has been acting in that role in the past from one of the major hospitals, and we are looking to legitimise that role as a department position, yes.

**CHAIR**—Can you tell us your view about a national strategy in terms of work force participation and work force questions about nurses? Do you think that it is tough enough in the ACT and that we do not want to go national yet, or do you see that it would be very good to do both?

**Ms Killion**—It is essential that we do both. It is certainly the ACT's opinion that we have to have a national strategy. At the moment, we are all just stealing each other's nurses and it is not really addressing the core issues and the core problems. We are just playing with bandaids here. We have to have a national scheme.

**CHAIR**—Are you 'stealing' from overseas or mainly interstate?

**Ms Killion**—Very few are from overseas is my understanding. But certainly interstate there is a bit of stealing going on, yes.

**CHAIR**—I am putting 'stealing' in parenthesis for me, but if you want it in parenthesis, please say. I suppose you could say 'poaching' or 'rustling'. Are you drawing nurses from overseas or mainly from other states?

**Ms Mowbray**—Other states, yes. I again speak on behalf of the Canberra Hospital in saying that we are not actively recruiting/advertising overseas at the moment. We have in the past, with limited success. It is possibly a strategy for later this year. They are advertising in Australia and we are advertising there. It is a bandaid approach.

**CHAIR**—From what we understand, there is an extremely exciting whirlpool of nurses moving out of Australia into the UK, from the UK to Ireland, from Ireland to America or Canada and into New Zealand, stop in the Philippines and do not pass South Africa. It is very

interesting. Some of it, as you have said, is because it is what people do. If you get trained as a nurse in Australia, you have a ticket to go to lots of places. They like the quality of Australian nurses. However, that does not help you, does it?

**Mrs O'Keeffe**—No.

**CHAIR**—In what ways are you predicting that you will take up the case for talking to educational institutions? You talk about a national intrasectorial approach. I presume that is the interface between nursing and education? Is it about nursing and hospitals? Is it about nursing and doctors? Is it just about nursing, hospitals, health and education?

**Ms Killion**—The latter.

**CHAIR**—So how are you already speaking to universities versus how you would like to?

**Ms Killion**—I think we are informally speaking to them now. We would like to very formally speak to them. We would like to be planning together. We do not. We are planning in parallel at the moment.

**CHAIR**—How do you see it would work? Are you doing any work on what kind of data and arguments you need to mount? Do you anticipate that it would be your minister who speaks to the education minister or do you believe it would be done at the bureaucratic level as well?

**Ms Killion**—I think both. Certainly, we can have those conversations at department level and ministerial level, if that is appropriate. Basic data is scarce at the moment. In terms of definitions of 'vacancy', if you asked everybody around this table you would have a different definition. Just raising awareness across the sector, and this inquiry, is opening the door for people to talk to each other. Essentially, I think people have been suffering in isolation. There has been very little talking, certainly within the ACT, across the organisations with the department. We have been invited now to participate in trying to deal with some of the strategies to help the situation out. I think this inquiry is a bit of a door opener for us in the ACT and perhaps also with other states.

**CHAIR**—That is useful. Thank you. We have certainly had evidence from other states and territories that the re-entry is a particularly challenging area. There are lots of nurses who might come back into nursing, but they roll their eyes at the notion of going to university; they might have to go to university when they have never done so before or have not done so for a long time and because they might have up-front fees of up to $10,000. Does it cost that much to do a re-entry program here?

**Ms Killion**—I am not sure of the exact amount, but it would be under $2,000, as I recall.

**CHAIR**—Under?

**Ms Killion**—Under $2,000. It would not be anywhere near the $10,000 range.

**CHAIR**—Perhaps I am confusing figures for getting a postgraduate qualification for 12 months or something of that sort.

**Mrs Maher**—From a Calvary perspective, we do offer an in-house refresher program for returning practitioners. It is not that costly. There is a $400 bond which is returned to them if they complete the course.

**CHAIR**—How long does it take?

**Mrs Maher**—About four months.

**CHAIR**—How many days and how many hours a day?

**Mrs Maher**—It is virtually full time, but they do consider part-time participants.

**CHAIR**—They do consider part-time

**Mrs Maher**—Part-time participants in that program. Some of them cannot commit to five days a week.

**CHAIR**—So it costs $400 and it is going to take them four months?

**Mrs Maher**—They pay a bond, yes, and it is actually returned to them when they complete the course.

**CHAIR**—How many have gone through and succeeded and stayed?

**Mrs Maher**—They usually run two or three a year and there are about six refreshers in each program, but not all of them complete the program. After perhaps six or eight weeks they find it is too much, they do not like it or they are not happy. They do not get their money refunded if they do not complete the course.

**CHAIR**—Is this a 9 to 5 or a practice for the 12-hour shift?

**Mrs Maher**—They have a number of study days, which are normal office hours, and then they have to be precepted with expert practitioners to upskill in their clinical areas.

**CHAIR**—'Preceptors to upskill'? I am learning new language in this inquiry!

**Ms Scott**—Last year the University of Canberra offered two refresher courses and one had to be cancelled for lack of numbers.

**Senator LEES**—What is the critical number?

**Ms Scott**—Fifteen went through the last course, so I think they take up to 15 to 20.

**CHAIR**—How different is it from the in-house one?

**Ms Scott**—My understanding is that it is three months long, full time. I think it costs about $1,800. All of those people actually received scholarships from the ACT government to undertake that course.

**CHAIR**—And do they actually also get precepted to upskill in the clinical situation?

**Ms Scott**—Yes. They are supported in the clinical environment.

**CHAIR**—How much time are they back in the wards or back in their community setting, getting their hands dirty?

**Ms Scott**—How much community work?

**CHAIR**—Out of a three-month course, how much of that time is upskill preceptor work?

**Mrs Maher**—At Calvary a fair percentage is actually based in the ward areas.

**CHAIR**—How much?

**Mrs Maher**—A fair percentage of it is based in the clinical area.

**CHAIR**—A fair percentage? Could you perhaps drop us a figure on exactly what that figure is, Ms Maher?

**Mrs Maher**—It would probably be 80 per cent.

**CHAIR**—And how soon do they get back into the clinical situation?

**Mrs Maher**—Fairly quickly. They are supernumerary, so they are not actually replacing anybody. That gives them an opportunity to observe for a number of days and to practise what they are taught in the first couple of study days.

**CHAIR**—Ms Scott, do you know about the university?

**Ms Scott**—I do not. You will have to ask the university.

**Ms Killion**—I believe it is a matter of weeks that they spend in classroom time. The rest of the time they are out in the clinical situation, but you would need to ask them to confirm that.

**Senator McLUCAS**—I have one question about the scholarships. Are they a bonded scholarship provided by the government?

**Ms Scott**—No. They have to be conditionally registered, they have to be in the public system already and they have to have three years postgraduate experience. Those are the only selection

criteria they need. We do ask them to stay in the public system afterwards, but we do not follow them up and we do not take the money back.

**Mrs Maher**—I might say, there is one entry criterion into the Calvary program—that they are not out of the work force for more than five years.

**CHAIR**—If they have been out of the work force for 20, what do they do?

**Ms Killion**—They generally go through the University of Canberra program.

**CHAIR**—Which is a three-year course? You can be refreshed after 20 years?

**Ms Killion**—I think that is difficult.

**CHAIR**—How many agency nurses are in Canberra?

**Ms Mowbray**—I do not know the exact number that we use at the Canberra Hospital. I can certainly provide those figures to you.

**CHAIR**—That would be very useful. Can you also tell me, whoever should answer this or provide the information, how many agencies are providing nurses in the ACT?

**Mrs O'Keeffe**—I think it is four.

**CHAIR**—And do you know what they are charging?

**Mrs O'Keeffe**—Level 1 nurses get $25 an hour. I do not know what they charge the organisation.

**CHAIR**—I cannot divide 34 by whatever it is these days any more. What does an ordinary nurse rate start at?

**Ms Mowbray**—We can certainly get that information to you.

**CHAIR**—That would be very useful, thank you. We have been given some evidence that it is perhaps a plus 20 per cent mark-up.

**Mrs O'Keeffe**—A casual on call at a hospital I think at level 1 gets $17 an hour, and an agency person who is the equivalent of a casual on call gets $25 an hour—in a nurse's take-home. I am not sure what the charge-out rate is to the hospital, but there is a difference in the—

**CHAIR**—There certainly is a difference. Do you pay for preceptors or does the university?

**Ms Mowbray**—No, the hospitals do. They are hospital employed staff.

**CHAIR**—How do you know they are able to be a preceptor?

**Ms Mowbray**—They have been through a formal course, a preceptor course.

**CHAIR**—That is taught where?

**Ms Mowbray**—In the staff development unit at the hospital.

**CHAIR**—So it is a hospital course?

**Ms Mowbray**—Yes.

**CHAIR**—And the university is satisfied that what you are teaching is adequate to the task?

**Ms Mowbray**—Yes. I should clarify. It is not supervision of clinical placement students, undergraduate students; it is for re-entry, refresher and postgraduate course participants.

**Ms Killion**—The universities employ their own preceptors for undergraduate students.

**CHAIR**—And are they in the wards but not working in the wards?

**Ms Killion**—They would be strictly teachers for the students. They would bring them to the hospitals or the clinical setting on the day.

**CHAIR**—But they would not actually lay a hand on a patient?

**Ms Killion**—Oh, they would. Absolutely.

**Mrs Maher**—They would not carry a patient load, but they would assist in patient care.

**Ms Killion**—They would assist the students in their patient care, yes.

**CHAIR**—They are surplus to the staff needs in the ward?

**Ms Killion**—Yes.

**CHAIR**—Are they paid extra?

**Ms Killion**—They are paid by the university. They are employed by the university, for undergraduate work, yes.

**Ms Mowbray**—The preceptors in the hospital—the staff that take on the role of preceptors—are not paid any extra.

**Mrs Maher**—And they do that in addition to their patient load.

**CHAIR**—That is what I like about this inquiry. Just when we think we have understood it, you introduce three concepts that say we have not got the picture at all. So there are two lots of

preceptors on a ward, some with university undergraduate students who are being paid by the university and some—

**Mrs Maher**—They are generally called clinical supervisors.

**Ms Killion**—You may just call them clinical supervisors. It will clarify the confusion. Sorry, I contributed to that.

**CHAIR**—I am extremely pleased that you think it has clarified it. Are you prepared to pay for more training places, for example for an intern year?

**Mrs Maher**—Calvary have just increased their establishment by a significant number to take on more graduate nurses this year.

**CHAIR**—How do you pay for that? Is that out of your allocation from the government?

**Mrs Maher**—We are hoping to get some. We have—

**CHAIR**—Yes, it is? You have already budgeted for it, or is it something you are going to talk to the other end of the table about when you leave?

**Mrs Maher**—Our budget process is happening at the moment.

**CHAIR**—We had evidence from earlier witnesses that a lot of enrolled nurses would like to do the bridging course and become RNs but there are no places easily available for them. Is this something you are giving consideration to?

**Ms Scott**—It will certainly be part of our discussions with the University of Canberra.

**Ms Mowbray**—We have commenced discussion with the University of Canberra that there needs to be a conversion course for enrolled nurses. We are losing enrolled nurses from our work force because they go elsewhere to convert to registered nurses. So we have commenced discussions.

**Mrs O'Keeffe**—The other issue about the enrolled nurse work force is that you have to understand that they are also in their middle 40s. The average age of the enrolled nurse is older, as well. When you do conversion courses you are not looking at—

**CHAIR**—I understood you to say that the average age of an enrolled nurse is old.

**Mrs O'Keeffe**—Yes, in her 40s. The same profile for enrolled nurses occurs for registered nurses, and if we are talking about conversion courses for enrolled nurses we also need to understand that we are getting an older person who is converting.

**CHAIR**—I think the idea of a 45-year-old being an older person is still, as I say, very encouraging! One of the things we have been told about—I think Senator Knowles raised it

earlier—is that evidence has shown that one of the times large numbers of nurses leave the profession is in their first year out. They hit the wards and they are not ready to run. In fact, it may be that they have not had enough clinical experience through whichever university course they have done. In some places that is changing. But we are told that it also is because when they get on to the ward they may be the only RN permanently employed. So as a baby, just out, they are suddenly supervising people who are older or senior but not permanent. They may be supervising agency nurses who are better qualified but perhaps do not know where the bandages are kept today. Some of you are nodding. Can you please comment on whether that is an accurate assessment?

**Mrs O'Keeffe**—I think that is a reasonable assessment.

**CHAIR**—It is an accurate assessment?

**Mrs O'Keeffe**—Yes.

**CHAIR**—It would seem pretty daunting to be a baby graduate looking after and supervising other staff.

**Mrs O'Keeffe**—A person in their first year out possibly would not be in that predicament but often a level 1 nurse would be in a role of supervising people— casual, on call; not permanent staff but agency staff on the ward they work in. It is not unknown, not in Canberra Hospital—I cannot talk for Calvary—but certainly in the private hospitals in the ACT to have four or five agency staff and no permanent staff on the ward at one time.

**Mrs Maher**—I think in the Calvary experience that would be more an exception.

**Mrs O'Keeffe**—I think that it would be, too.

**Ms Mowbray**—As well as at the Canberra Hospital. There are certainly odd occasions where that happens, but it is not the rule.

**CHAIR**—Could you tell us your thoughts about national registration? What kinds of conflicts are there between state laws, to your knowledge? Also, regarding the problem of a national curriculum, how would your registration board cope with that?

**Mrs O'Keeffe**—I am probably speaking personally here and I have got support from my colleague on the board, there is a theory that there should be a national standard around nursing registration and education. We have had things like mutual recognition policies where if someone is registered in New South Wales they can be registered in the ACT and vice versa. There is a theory that registration needs to be managed locally to understand the local work force and the issues within the work force. So the idea would be to have an overarching program of registration but it would be managed locally. I think I am right in saying that.

**Ms Parke**—We have certainly discussed it at our board level and we have concerns about if we went down the track of national registration per se without strict guidelines. With mutual recognition, what we do not accept here, because of the public safety issue, is accepted

elsewhere. Then if they are registered elsewhere, they automatically, because of mutual recognition, can attain registration here where we may not have been willing to register them because they may have required retraining. There are some other areas. Overseas people may not have met what we require with our English standards. So the mutual recognition is enough of a problem without national registration, if we go for the lowest common denominator, and not for the public safety aspect, just to address a shortage.

**CHAIR**—I do not understand from my question that asking about national registration means seeking a lowest common denominator. I am interested that you make that comment.

**Ms Parke**—We have talked about the impact of a national registration, if that is what you are after—whether we would be registered to work anywhere within Australia and not have to be done state by state and by territory. Is that what you are talking about?

**CHAIR**—I think that probably a national registration may be what is required. There would have to be registration boards in each state and territory, just simply for the convenience of getting at them. Before we go further, have you anything further to add on that? Have you had any meetings about it?

**Ms Parke**—No, we have not. We have just had discussions regarding it at our respective board meetings at times.

**CHAIR**—If this report were to recommend a national registration, would you all celebrate?

**Ms Parke**—Probably not, unless there were very strict guidelines for what the people were to achieve before they were registered.

**CHAIR**—Do you have to go to the university and tick off on the curriculum that the nurses are doing? So you are saying that it actually has to run past you? Okay. We have heard today that there are some course deficiencies or, if not course deficiencies, it is very difficult, for example, to get experience as a community nurse. At the moment, the undergraduate course offers two days in three years as a nurse looking for community experience. Do you have a view about the sufficiency or not of that?

**Mrs O'Keeffe**—I think when you are designing curricula, there are lots of things that people try to put in curricula. There are lots of needs to be met and you need to make priorities around those needs. The aim of the undergraduate nurse education, I would suggest, is to create a nurse with a core level and standard of knowledge that can be developed on after his or her initial education to specialise in the skills that they require. We are always trying to put more and more into the curriculum to make people more and more aware of the issues surrounding it. Sometimes we do that to the disadvantage of the student, because we do not skill them up in the prime things that they need to be skilled up into.

**CHAIR**—We have passed the time we have—I am so sorry, because it is just a very fruitful session. If you have any information that you could pass to us—and certainly please not a major thesis; just dot points—on your views on a national marketing strategy or a local one; what you are doing and what you are planning to do; if there is anything that you can say about a concern

that we have had raised with us, which is the violence within the profession, and whether you, as the department, are looking at setting out some steps to address that; and also the concern that we have had raised about non-qualified people giving medication, in particular carers not qualified as ENs or RNs particularly in the aged care area. Does this cause a problem? Is there local legislation that restricts who can handle certain medications under poisons law and so on? If you could tell us that this is an area of concern, or if you have not had it raised, we would appreciate some comment about that. Finally, Ms Killion, if there is any further information that you can offer us about pay scales, starting levels and increments, and any comparisons with the rest of Australia, that would be really excellent, but only if that is easy.

**Ms Killion**—We will be happy to do that.

**CHAIR**—Thank you very much.

[5.43 p.m.]

**MILLER, Ms Catherine, Chair, Nursing Task Force, Australian Private Hospitals Association; and Chief Executive Officer, Wakefield Hospital, South Australia**

**ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association**

**CORMACK, Mr Mark, National Director, Australian Healthcare Association**

**PARIS, Ms Barbara, Catholic Health Australia; and Director of Nursing, Mater Hospital, North Sydney**

**SULLIVAN, Mr Francis, Chief Executive Officer, Catholic Health Australia**

**CHIN, Ms Lee, Manager, Strategy Development, UnitingCare Australia**

**HATFIELD DODDS, Ms Lin, National Director, UnitingCare Australia**

**SHAW, Mr Bruce, Senior Policy Officer, UnitingCare Australia**

**THOMAS, Ms Cara, Deputy Operations Manager, UnitingCare Australia**

**TOOHEY, Mrs Joanne, Operations Manager, UnitingCare Australia**

**CHAIR**—I welcome representatives from the Australian Private Hospitals Association, the Australian Healthcare Association, Catholic Health Australia and UnitingCare Australia. I do thank you for being prepared to come in this panel arrangement. We are trying to have the opportunity to hear from as many witnesses as possible in a pretty restricted time frame, so we appreciate your preparedness to participate this way.

The committee prefers all its evidence to be heard in public, but if you wish to give any comments in camera you can ask to do so and the committee would give consideration to your request. We have before us your submissions 835, 890, 897 and 871. Does anybody wish to make alterations to their submission? Then I might ask you to make brief comments and then field some questions. Could we start with the Australian Private Hospitals Association.

**Mr Roff**—Certainly. I do have a prepared statement, but to assist the committee with its time constraints I will just touch on some of the key elements. Without going through the information that was provided in our submission, I just want to mention a couple of initiatives that APHA is involved with.

**CHAIR**—Are you prepared to provide a copy of that to the committee after you have finished talking to it?

**Mr Roff**—Yes.

**CHAIR**—Thank you.

**Mr Roff**—As I said, we have established a nursing recruitment and retention task force, of which Ms Miller is the chair. That has been examining this issue and has come up with a number of initiatives. The first one relates to a bonded rebate of HECS fees. Feedback received from our member hospitals and directors of nursing indicates that a key impediment to increasing the size of the nursing work force is the impact of HECS on trainee and graduate nurses. Indeed, the discussion paper produced by the government's national review of nursing education indicates that approximately 40 per cent of registered nurses in the 19- to 21-year age group are exiting the profession. Therefore, the APHA has submitted a proposal to the Treasurer for the introduction of a bonded rebate of HECS fees. Just very briefly, what we have proposed is that for every year a graduate nurse worked in a hospital—public or private—they would receive a rebate the equivalent of one semester's HECS fees. So after six years of working in hospitals they would effectively not have any HECS liability.

**CHAIR**—Is that the undergraduate program, or is that for the graduate program?

**Mr Roff**—It is the HECS liability that is incurred during the undergraduate program. In relation to education and training, we believe that undergraduate nurse trainees need to be placed in hospitals at a much earlier point in their education. This proposal has two main components: a redesign of undergraduate nursing courses to incorporate the early placement of students in hospitals and, secondly, the articulation of these students through positions at different levels depending on their attainment of specified competencies. If sufficiently well designed, students should have the opportunity to move through the different levels; for example, beginning as a ward assistant, becoming at a certain point an enrolled nurse and graduating, as they do now, as a registered nurse. We believe that redesigning courses around these parameters would offer students early experience of hospital work, may help to break down some of the barriers between hospital nurses and newly graduated nurses, and also improve the expectations of graduated nurses. This could be complemented by the greater use of experienced nurses—practising nurses—in universities as either visiting lecturers or tutors to bring a real life and current flavour to the undergraduate teaching of nurses.

**CHAIR**—You are suggesting that part way along, maybe after two years, a nurse under this program could be equivalent to an EN?

**Mr Roff**—Yes.

**CHAIR**—Have you thought through the possible conflict of an EN second year through university compared to an EN through TAFE?

**Mr Roff**—There would obviously be some transitional issues there that would have to be addressed. I heard the committee talking about a national marketing campaign. We would certainly be supportive of such a proposal. We believe there is merit in a national approach to the marketing of nursing as a career. In fact, we have written to the Minister for Health and Ageing on that issue asking that it be placed on the next meeting of AHMAC.

I also want to raise the issue of nursing agencies, which are causing particular problems for hospitals at the moment in terms of charging and other practices. We have provided two submissions to the ACCC giving details of charges and practices by nursing agencies that, in our view, amount to an abuse of market power. Just by way of example, we have undertaken some very conservative calculations that indicate that the increasing reliance on agency staff is adding in the order of 11 per cent to total private hospital costs—and they are conservative figures.

**CHAIR**—Would that report or submission be available to the committee?

**Mr Roff**—I can check with the ACCC. As long as they have no problem, I am happy to provide it.

**CHAIR**—We would appreciate that.

**Mr Roff**—We have also written to the Minister for Health and Ageing proposing that an urgent national inquiry be undertaken into the charges and practices of nursing agencies. We understand that such an inquiry would have the support of all hospitals, public and private. We believe the current focus on the nursing work force is both welcome and overdue. Our health system and hospital system simply cannot operate effectively without an adequate supply of appropriately trained nurses. We therefore look forward to the recommendations and the report of the committee to assist in finding some practical solutions to this problem.

**CHAIR**—Thank you, Mr Roff. Now the Australian Healthcare Association.

**Mr Cormack**—Thanks for the opportunity to present today. By way of opening comment, there is an apology from Deborah Green, our national president, who is unfortunately caught up in the airline difficulties today and cannot be here.

I guess our comments are not along a dissimilar vein to the comments by the Australian Private Hospitals Association. Our members are the largest group of employers of nurses in Australia, and our comments and our submission in fact focus on the employer perspective. We have addressed in our submission the impacts of work force shortages. I would just like to highlight those that are borne heavily, though not exclusively, by hospital and health care employers: firstly, the reduced ability to deliver the range of services for which we are responsible; secondly, diminished operational efficiency due to disruptions to scheduled service delivery and under-utilisation of human and other resources; increased costs associated with recruitment, overtime and temporary staffing arrangements—I will come back to that one in a little while; differential impacts on providers, with more negative impacts being experienced in rural areas, within certain specialty areas such as operating theatres, intensive care and aged care; increased organisational risk related to unforeseen shortages of staff, loss of critical corporate knowledge, age-related employee health status and quality of care concerns related to diminished continuity of staff; and finally, our reduced ability to respond to emerging health care diagnostic and treatment modalities.

Our submission really proposes a balanced look at this whole issue of nursing work force shortages. In doing so, we talk about the supply side and the demand side. The supply side has

certainly been well canvassed and refers to initiatives and policies that seek to increase the number of qualified nurses available to the system through education, remuneration, scholarships, inducements, incentives, et cetera. These have been well canvassed and we in general support those that are nationally coordinated, sustainable and affordable. In talking about the demand side, which is what we wish to focus on, we are referring to policies and initiatives that answer the fundamental question: are all the duties and roles performed by registered nurses only able to be undertaken by registered nurses? We would contend that while ever labour shortages are likely to persist—and we believe they will—and while ever there is a limit to what can be achieved by supply side actions—and we believe there is—it is therefore timely to closely examine and analyse the roles and professional boundaries that currently apply to registered nurses employed within the health care sector.

One of the demand side effects is the variation in the use of related categories of staff to perform duties currently performed by registered nurses. These categories include enrolled nurses, level 4 of the Australian Qualifications Framework, and assistants in nursing, level 3 within that framework. There is considerable variation in the use of para-professionals—and I am terming levels 3 and 4 within that category—across the states and also across the sectors. We believe it is timely to explore in some greater detail the appropriate use of a flexible mix of registered nurses, AQF levels 4 and 3, in a wider range of health industry employment situations than they are currently used. This would necessitate a detailed consideration of the range of duties able to be performed by such staff, areas of overlap between staff categories and, clearly, the supervisory roles of registered nurses.

We recommend that a review process be established to look at associated competency based training requirements and improved articulation of training for each level. A recent example of such an exercise is the review of the current role of enrolled nurses in the aged care sector, Future Directions 2001, which was undertaken by a working group under the auspices of the Minister for Aged Care’s National Aged Care Forum. While this study was largely confined to the aged care sector and to a specific nursing function—that is, the administration of medication—it does serve as a useful model for a more comprehensive process of exploring this issue. We believe that a flexible approach to addressing the need for nursing skills may have benefits for the industry, for nurses and for a range of other workers with a lower level of formal education yet who may be able to make a constructive contribution to the nursing work force shortage and the provision of health care.

In the area of work force planning, we believe that much more can be done to coordinate actions at a national level. AMWAC, the Medical Work Force Advisory Committee, provides a quality advisory, monitoring and policy resource for medical work force planning. While its recommendations are only as useful as the preparedness of governments and training authorities to implement them, it does provide a means for national coordination. We note the establishment of AHWAC, the Australian Health Work Force Advisory Committee, in December 2000. We look forward to a similar degree of effort and resourcing for the planning of the non-medical profession work force. We also believe that monitoring of performance and accountabilities of each of the stakeholders—that is, government, training authorities and professions—in meeting the work force planning recommendations of AHWAC could be strengthened.

We also believe that there needs to be improved input into the content and format of nurse training and education programs. We believe that, while there is an overwhelming benefit accruing from the current university based three-year program, there could be improvements to the practical clinical preparedness of newly graduating staff by increased opportunities for clinical training, placements, exposure to practice at an earlier stage in the registered nurse education program, flexible and modular programs that encourage articulation of training across the various categories of nursing and related employment—and the Private Hospitals Association made mention of such a model and we support that—part-time industry related employment for nursing students, and to secure a reliable supply of skilled labour that could perform a range of tasks currently performed by nurses but which may be as effectively performed by persons with lesser training.

Our final comment is to support the need for investigation of the current practices of nursing agencies. Salary costs account for 60 per cent of overall operating costs of hospitals and nursing staff account for 50 per cent of that. We believe that the Commonwealth, through its funding responsibilities for 50 per cent of the public hospital sector, 100 per cent of the veterans health care program and the private health insurance rebate scheme, has a legitimate policy and financial interest in containing the cost drivers associated with these programs.

**CHAIR**—Mr Sullivan.

**Mr Sullivan**—I thank you once again for the opportunity to address the committee. I am very pleased that we can have Barbara Paris here, the Director of Nursing at the Mater Hospital in North Sydney, to be part of our delegation today. Catholic Health Australia is the largest non-government provider grouping of health, aged and health related community care services in the country and, like everyone else around the table, recognises that there is a crisis in nursing. Either on the hospital or the aged care side, our providers at the service delivery end experience this crisis in a very severe fashion. As an example, on the same day a hospital is paying one fee for an employed nurse and another far higher fee to an agency for the same nurse.

In aged care our managers are struggling to have proper nurse coverage and, when it is not available, are experiencing the same dilemma as are hospital managers when it comes to employment. You may have noticed in the latter part of last year in Victoria one of our agencies had to go to the extreme case of paying an agency $200 a day to ensure that they had nurse coverage for that day. On checking with that agency today, the situation has not changed. They are obviously not paying $200 a day to the agency, but they are still struggling to find enough nurses in order to meet their legislative requirements for coverage. Hopefully we will return to questions on that later.

From a public policy perspective, Catholic Health Australia has the same concerns as the government. We have an exposure in the public and private hospital sectors, residential aged care and across the community care sector. Appropriate levels of staffing are fundamental to the delivery of quality care, and we would all agree that a proper balance, as the AHA has already said, is needed in the nursing staff issue. We advocate in our submission for a formal process to assist the existing supply, distribution, remuneration and future planning of the nursing work force.

The main focus of this inquiry is to examine the shortage of nurses and the impact this is having on the delivery of care. We have submitted to the Senate five priority areas for the government to address. The most pressing priority for our hospitals and aged care providers is the need to staff our facilities. I put it to you that the staffing of facilities is the highest priority. We understand that the training, the strategic marketing and the nature of the courses in university are equally important, but when one has to prioritise it is about getting people to the service delivery end as soon as possible.

The drain from aged care to the acute care sector has partly been due to a disparity in wages of around 20 per cent between the two sectors. We know that that disparity is not as large in New South Wales, but certainly in Western Australia and Victoria, to name two other states, it is 20 per cent—if not higher—in some cases. The Senate must consider ways in which agencies function. This has already been mentioned by the two previous associations. But we do not have a problem with just wage outcomes. In fact, we encourage it. Where we have difficulty is where an agency benefits from the wage process and the agency nurse does not. In many instances, aged care providers have their hands tied due to requirements arising from legislation as well as their ethical requirements on duties of care. The government does not provide the real costs of wages in aged care. It only provides a contribution towards wages and salaries, and caps the fee structure such that it is not possible to meet the escalation in costs.

CHA has submitted, both in our budget submissions and to ministers directly, that the Commonwealth own purpose outlays indexation method, the COPO, is an inappropriate method of indexing funds for residential care at least, if not into the public hospital sector in their own indexation formula and out into other Commonwealth subsidies of community aged care. This is in our submission so I will not go through it now, but basically we would recommend a change to average weekly ordinary time earnings or a wage cost index for measuring wage costs, and the consumer price index for measuring non-wage costs would be more realistic and lead to more effective, viable and higher quality aged care residential facilities.

CHA recognises that nurses training and career development are important strategic issues. They are needed to address the supply of quality work force. But governments, as the major funders of hospital and aged care services, must equally recognise their responsibility to enable services to meet wage cost pressures. It is one thing to laud the reputation of our health and aged care services. It is another to resist meeting the real costs of care. This scenario applies across public and private sectors. We must not slip into a minimalist agenda where a person's entitlement to essential care is comprised of basic services stretched by inadequate funding and overworked staff. If quality is to mean anything, it must be the driving force not just of service delivery but of basic funding allocation decisions, in the first instance, adopted by government budget making levels.

There is an urgent need for government to address the education and training issues for nursing across all of the specialist fields but particularly the interface between universities and the health care system. What collaboration is there currently between this inquiry and the terms of reference for the national review of nursing education, which has recently released a discussion paper following the first phase of the review—we put that question to the Senate. The issues affecting the nursing profession are complex, and we submit that any approach by government to address the shortage that exists has to be in the context of a multifaceted strategy.

As mentioned previously, we also would support a national marketing campaign. We also have no problem with the notion of a national registration process. When it comes to aged care in particular, there need to be nationally consistent approaches to medication, distribution and the interface with state governments' poisons legislation. CHA has called for a nursing support package to be put in place in the forthcoming federal budget to address the current shortage that exists, and we are currently involved in another forum in the national review of nursing and we obviously would be pleased to participate in any way the Senate requires to develop further strategies for the sector.

**CHAIR**—UnitingCare Australia.

**Ms Hatfield Dodds**—UnitingCare is one of Australia's largest welfare networks, providing services to well over a million Australians. It gives expression to the Uniting Church's commitment to support individuals, families and communities by providing caring services. I am speaking to a statement that we can give you later. It is not directly in our submission. The UnitingCare network is one of Australia's largest providers of residential and community based aged care services, so our focus today is the aged care sector and the framework we bring to it is the best interests of the older person.

It is our experience that the shortage of nurses and other qualified care staff in acute care and in residential and community aged care is placing pressure on Australia's continued ability to provide a skilled and dedicated nursing and care work force into the future. We do have a crisis. Lucan Care, one of our facilities in Western Sydney, spends $45,000 each month on agency nurses for two high care facilities. The deputy director of nursing spends half of each day organising staff rosters and replacing staff. This is becoming normal for the industry. If committee members would like to talk to people on the ground, UnitingCare Australia would be really happy to facilitate visits to services.

Generally on aged care, we would advocate a national strategic response to the nursing and other aged care worker shortage crisis. We believe that long-term measures to address staffing levels and skills mix are vital. The recruitment and retention of quality staff in aged care is adversely affected by excessive documentation and accountability and inadequate rates of pay. The word we keep getting from our network is that documentation is a much larger issue for people on the floor and facilities than the wage disparity, although that is certainly a concern for our network. Care staff are basically interested in caring. The sort of person entering the caring professions has a finite and often low tolerance for bureaucracy. The increased documentation requirements over recent years have led to a difficulty in recruiting and retaining caring staff. The often adversarial approach of the resident classification scale, or RCS, validation system and accreditation processes has increased workloads and created stress for care staff, affecting morale. Then there is the wage disparity between the aged care and acute care sectors, as was mentioned before, of up to 20 per cent—sometimes we have heard up to 30 per cent, depending on where you are in the country.

Aged care providers' income streams are heavily regulated and controlled by the Commonwealth in terms of charges that can be levied in both residential and community settings. The aged care sector is also heavily regulated in terms of service provision and facility

quality. An example is that building regulations specify distances from workstations to residents. All of these things are significant drivers of provider cost.

The Commonwealth sets the regulatory environment and so has a huge impact on both recurrent income and expenditure and, therefore, on the ability of the aged care sector to offer salary parity while remaining viable. The National Aged Care Alliance, a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals, is sponsoring a national forum on long-term financing of aged care in June this year. It is our hope that this will help generate the sort of public policy debate needed around these issues.

**Mr Shaw**—To assist our understanding of how different social and political environments may affect the future provision of aged care in Australia, UnitingCare New South Wales-ACT has undertaken an extensive scenario planning exercise to help us think about different possible scenarios. The scenario planning document, *Alternative futures for aged care in Australia,* is included in the package of information we will be giving to you.

In 1999 the Productivity Commission made a recommendation to introduce aged care funding based on robust benchmark indicators of care. Society today is demanding that care models should go beyond the clinical model and incorporate quality of life factors as well as quality of care. UnitingCare Australia is undertaking national research to establish benchmark indicators for both quality of care and quality of life in aged care, to establish what links there are between these and to establish robust indicators for what staff, with what skills mix, and what resources are needed to provide for this. This project is the initiative of Blue Care Queensland, the Queensland University of Technology Centre for Nursing Research and UnitingCare Australia. The National Aged Care Alliance is also a project partner, and a brief on that project is also included. We believe that this research will be crucial to the development of viable national benchmark indicators as recommended by the Productivity Commission.

In acute care, nursing staff in hospitals are subject to the same sorts of extreme stress as in aged care. Long waiting lists and the consistent need for overtime are causing unrelenting pressure. It has been put to us that the crisis is every week. Hospitals must use nursing agencies for temporary staff for the same sorts of reasons as aged care facilities, and with similar consequences of heavy costs and no continuity of care. Uniting Health Care in Queensland report less problem with recruiting and retaining care staff than some other acute care organisations, and certainly less than our own aged care facilities. They attribute this to a highly successful recruitment campaign and a family friendly work environment, including flexible hours. Uniting Health Care in Queensland also reports that, while the government's private health insurance rebate has resulted in additional patients coming to their hospitals, this is not reflected in the income from the health insurance funds increasing in equivalent terms and so is causing additional financial pressures.

There are significant linkages between acute care and long-term care. An improved interface between acute, aged and community care is vital to solving many of the problems common across these sectors. UnitingCare Australia believes that providing properly resourced health and aged care services through a better integrated mix of community based, residential and health and hospital services is vital. For example, long waiting lists for admission to residential

homes or acceptance for community care programs mean that many people who no longer need acute care are languishing in hospitals. This is not good care. From the economic perspective, it is irresponsible cost shifting and cost adding which is contributing to the enormous pressures on the public health system. As well as this introductory statement and the attachments that I have referred to, we also have a short statement with some additional comments and some case studies that you might be interested in.

**CHAIR**—I think that would be splendid, Mr Shaw. I suspect that everybody would like them, if I could judge the interest of other witnesses, but I mustn't speak for them. I would simply open the batting by saying that I have been able to listen to many of you and lots of other people make submissions over the time, but rarely—do not get swollen heads—have I sat here listening to four such excellent submissions going so well to where we should go. I very much appreciate your contribution.

**Senator KNOWLES**—Mr Roff, you argue in your submission that there is a lack of an integrated public-private approach to nursing. Would you care to elaborate and explain how that should be addressed?

**Mr Roff**—I might actually defer to my colleague in the first instance.

**Ms Miller**—What tends to happen is that at a state level, when committees are formed to address issues such as nursing recruitment and retention or the curricula in the tertiary sector, they are predominantly filled with public sector appointees. It is very difficult for the private sector to have an input into either the tertiary university sector or nursing issues in the states.

**Senator KNOWLES**—What is the barrier?

**Ms Miller**—I think it is generally that when committees are formed various representations from the larger hospitals tend to dominate.

**Senator KNOWLES**—What have you done to overcome that barrier?

**Ms Miller**—We have tried to get our own act together, too. As you know, the private sector is a bit disparate with multiple groups and different factions, ranging from for profits through to church and charitable. We have tried to, particularly through this exercise, get together and get our own act together first. Some states have managed to gain representation on the state committees.

**Senator KNOWLES**—What have they done to crack the barrier that needs to still be done in the remaining states? Have they got some secret formula that they have been able to do it and the other states are still trying to?

**Ms Miller**—I think it is persistence. Certain states will have bodies that have more time and commitment to create that persistence, whereas in others they are functioning directors of nursing in the main and they have to deal with the day-to-day problems of trying to fill rosters. The actual time that it takes for operational directors of nursing to become involved in policy debate is quite limited.

**Senator KNOWLES**—Would you mind explaining to me what difference, if any, there is in the incomes and conditions for nurses in the public and the private sector?

**Ms Miller**—They vary from state to state. In Queensland in the private sector they are slightly below the public sector. In South Australia, where I come from, they are slightly below but in two private hospitals there is a parity. And in Victoria they match.

**Ms Hatfield Dodds**—In New South Wales the private sector is behind the public sector. It always has been. It is certainly an issue that has been brought up with the professional association, the New South Wales Nurses Association. That is also one of the reasons we get people leaking from the private sector into the public sector. Once they get into the public sector, the additional issue is that when they actually build up their entitlements—long service leave, superannuation and such—it is non-transferable into the private sector, obviously because it is a different pool of funding. So it is very difficult to get experienced people out of the public sector and into the private sector. I think that is certainly an issue that really needs to be addressed. It might need to be at each state level, but certainly there should not be differences between working in the private and the public sector.

**Senator KNOWLES**—How do you see it being changed, though?

**Ms Hatfield Dodds**—I think probably the private sector needs to be a little bit more proactive. It has been in the past. I can only talk from the New South Wales viewpoint. I guess it is probably being more and more proactive with the New South Wales Nurses Association. When there is an inquiry into nursing, if it is an issue that can be raised through such an inquiry, is another avenue through which there will be some additional pressure, shall I say, to make people start talking, because I think it is essential.

**Senator KNOWLES**—Mr Sullivan, do you think it needs to come from the association up, or does it need to come from the management of the private hospitals down, where there is a decision made to grant parity in an effort to retain the staff that are so dearly needed?

**Mr Sullivan**—Just staying with hospitals, you would probably find that many hospitals would not take kindly to their association telling them. It seems to me, from what we understand, that it is patchy and therefore some hospitals are more adept at negotiating a better set of conditions than others. So I think they would resist, in some cases, people imposing from above that ‘this is the way it will have to be,’ ‘make sure you get parity,’ and so on. Most sensible managers are trying their darnedest to work out a way in which they can retain the nursing staff. In some sense we would not be dreaming up anything new.

It does go to that other point, though. If we want to slip across and talk about the public hospital issue or the aged care issue, about how they retain staff, their hands are more tied in some sense because of the funding model they are under. I think the issue in the private hospitals—it was alluded to in the UnitingCare introduction—is the fact that health funds at the moment at best are funding like state governments fund hospitals, on a recurrent basis. Sometimes the growth factor in those budgets—maybe Michael can talk about this—are not being met by real cost increases by funds. Therefore again you have got the problem. If you can foresee that next year there is going to be a wage blow-out you are really left with trying to

negotiate an increase with the health funds which, on their side of the story, are trying to limit outlays because they have pressures such as inflationary pressures, premiums and so on. The system is in a very tight bind if you look at either sector or either component.

**Senator KNOWLES**—It seems to me to be a bit skew-whiff, to say the least, if we are saying that the pressures are there in costs and to give parity—and I understand that—and yet, by not doing so one is forced to pay a higher rate for agency staff, which would have, to my mind, a more deleterious effect on the budget than being able to give parity.

**Mr Sullivan**—I think some of it has to do with the amount of resource supply available at a given time.

**Senator KNOWLES**—Mr Roff, would you like to comment?

**Mr Roff**—I do not know that the issue of parity is necessarily the relevant one there, because quite often nurses will tell you that the conditions in the private sector are more attractive. So the money is not as important.

**CHAIR**—Like what?

**Ms Miller**—Flexibility of hours; you do not have to rotate over shifts; if you want to only work earlies, you can. If you need to attend to family matters there is a lot more flexibility in both rostering and leaving the work area for problems with children and changing times. There is usually quite a lot of support for people with their own personal problems.

**Ms Hatfield Dodds**—Many of our providers are using fringe benefits to try to balance the parity issue out of it. Certainly, from our network, I guess I could not stress enough that our agencies keep saying that for nurses on the floor the prime issue is documentation, and vast amounts of documentation. That is the issue about both recruitment and retention of staff both in terms of the initial recruitment and in terms of trying to get nurses who have been out of the work force back in. There is this real documentation barrier.

**Senator KNOWLES**—Can I ask UnitingCare what I asked of previous witnesses: what should we be doing to try to attract more young people into the specialty of aged care, to make it an attraction for them to want to go in there as opposed to saying, 'I never even thought of it'?

**Mr Shaw**—It seems to me there is no simple answer to that. There is the problem of wages but there is also the problem of the climate, the culture, if you like, of working there. There are so many other alternative employment avenues these days and nursing has lost a lot of its appeal. Some of those reasons have been documented in the statements to you such as the excessive documentation. So nurses are not actually doing nursing, increasingly—certainly in aged care. There is also the pressure and the stress that come about from constant surveillance, if you like, by the accreditation agency in aged care, by the RCS validation teams. It is not seen out there in the community as a pleasant environment to work in. The national strategy that we are advocating obviously needs to address the educational aspects—making it easier for people to move into nursing courses at the universities. But it also needs to address the cultural aspects of the attitude out there to nursing.

**Ms Hatfield Dodds**—I would say probably the two big things we could change are perhaps the regulatory environment that operates in aged care that nurses on the floor in facilities are living with and perhaps looking at the education and training of people coming into nursing. We were talking today about the fact that, in terms of training in gerontology or training as a nurse working in aged care, it is not really seen as a desirable place to end up. Perhaps some work in educational institutions about raising the profile of a career in aged care would be great.

**Senator LEES**—Do you assist with placement of students in your nursing homes?

**Ms Hatfield Dodds**—Yes, some of our facilities do.

**Senator LEES**—Are you, with facilities in various states, able to compare university courses? From what I can piece together, in some university nursing courses aged care is actually a core component; it is part of a core curriculum. In some places it is an option and you may only be able to tap into it in third year when you have probably made up your mind what you are going to do, anyway. I have found at least one that does not seem to have any aged care component. It is a picture that I think the committee is going to have to start putting together. Can you help us at all with what you find in that area in terms of the options?

**Ms Chin**—One of the comments that comes from a number of our directors of nursing and our chief executive officers is that aged care is not promoted as an area of specialty, yet when you are working in the aged care field it is an area that has a high need for specialist knowledge, and there is the fact that there is not that common thread through the universities as to where the specialty can be gained. Our experience is that the people who are coming through are having less and less knowledge of aged care or even being given the option. So that is our concern: promoting it as a specialty so that it would come back to the universities, and there is not a consistent approach, even within the state.

**CHAIR**—Do you notice a difference between nurses who are ENs as opposed to the university educated ones?

**Ms Chin**—I would actually walk around that comment by saying one of the things we are noticing is that there is absolute value in having ENs and RNs in aged care.

**CHAIR**—A very elegant answer. Now can somebody actually answer the question more seriously? If I raise a humorous response from every witness at the table I really need to know what I have fingered, please.

**Mrs Toohey**—I would rather have a hospital trained nurse, whether it be an enrolled nurse or a registered nurse, any time than a university trained nurse.

**Mr Shaw**—But the fact is that they are not available.

**Ms Paris**—Actually, I am very different. I actually think you need university educated nurses with the high technology and the high degree of knowledge that is needed these days to nurse a patient. Yes, you can supplement that, and we are all doing it in the hospitals with the different skills mix. We are all starting with RNs, ENs, assistants in nursing, patient care assistants or

whatever we like to call them. We are submitting those. That is already happening in the hospitals because there are not the RNs out there.

**CHAIR**—Excuse me, I thought the question was about whether in the undergraduate course nurses get to know anything about aged care, and you were answering that. Then my next question was: do people doing EN courses get to know anything about aged care, or are they actually being trained to go into aged care and is it different? I am terribly interested in the answers you have given me. The different paranoia will out.

**Mr Shaw**—The community services curricula—the health fund community services ITAB—are quite specific. There are quite specific chunks for gerontology, for aged care type studies. So hopefully people doing the EN course within that who want to work in aged care will be doing the aged care components of that. That is currently being reviewed. We are putting together a new package. We actually have some difficulties with that, I might mention to you, because someone somewhere has made a decision to lump aged care with disability. We do not think that is actually a very good idea. They are separate at the moment.

**CHAIR**—Sorry, Senator Lees.

**Senator LEES**—No, this is all along the lines that I was heading down in terms of your interaction with trainees or trainers. We heard earlier today from Community Care here in the ACT that they have actually been working directly with Canberra University trying to solve some of their problems. Do any of your organisations—or perhaps at a managerial level in your associations—have any direct contact with either the universities or the TAFEs looking at either what enrolled nurses are doing or the numbers of nurses who are actually being trained?

**Mr Shaw**—Yes. In the additional information that we have given you in the pack there are some examples of that in New South Wales and Queensland. I am sure they exist in other states as well, but they are the ones that we got access to. It is not going to solve the problems of the world, but I think they do provide a good model. One of the problems with it is that they are not necessarily recognised for funding purposes by the Commonwealth and it is not always easy to get the qualifications recognised, either, in terms of prerequisites to get into the university courses. We advocate that there should be easier bridging ways of going from an EN to becoming a registered nurse, for example.

**Ms Chin**—Can I make some comments about that as well? A number of our organisations at a local facility level do develop relationships with TAFEs to provide on-site training and opportunities for practical experience and some of our organisations have connections with universities. Wesley Gardens and La Trobe University have a connection. The other one that would be interesting is that our central office organisation has funded two nursing scholarships through the University of Wollongong. That means that those people are people who are working as assistants in nursing and could not afford to do nursing training but who wanted to work in aged care. So a significant chunk of their training is done through Wollongong University. So we found that that relationship with the university has given aged care more of a profile in the nursing faculty there. But that is a very local sort of relationship.

**Senator LEES**—This is what we are looking for. We are looking for some success stories that are working here and there, and trying to build a bigger picture of what works.

**Mr Shaw**—What we have given you in the additional comments there is some of the information about it. We have also given you contact names and phone numbers and email addresses so you can actually follow it up if you want to. We would be happy to facilitate further discussions with you or visits by you to these facilities. Certainly, from our perspective, we believe very strongly that closer links between the industry and the academic institutions are vital if we are going to start to come to grips with the problem.

**Mr Sullivan**—In our sector, we have at least four sponsored chairs of nursing in hospital university settings: three on the east coast and one in Western Australia and also in Lismore through the Southern Cross University, and at St Vincent's Lismore Hospital there is a process now of trying to engage school students directly in nursing, not just at the hospital level. So, again, we can make contact details available, through your secretary, of examples like that.

**Mr Cormack**—A best practice example would be Notre Dame University in Western Australia, which has got a formalised partnership between an educational provider and the industry. So it is able to solve the problem that we have identified, which is lack of clinical preparedness in undergraduates and also provide some opportunities for earlier entry into the work force. I think that there is another one, which may have already come up in evidence before, and that is in the Northern Territory where they effectively collapse a university degree down into two years and are able to bring on supply at a much earlier point in time.

**CHAIR**—Is that by running over 12 months?

**Mr Cormack**—That is correct. It does not reduce the quality.

**CHAIR**—Thank you.

**Ms Miller**—The two best examples that we have are the two—I think that it is Deakin in Victoria and Ballarat or Bendigo—that have a fast tracking of enrolled nurses to registered nurses.

**Senator LEES**—If I could just ask in a hospital setting, you mentioned, Ms Miller, shifts being flexible and more attractive than in some of the public hospital routines. Have you trialled different lengths of shifts, like 12-hour shifts? What is your experience in terms of what works?

**Ms Miller**—We had a nurse-initiated 12-hour shift research proposal within intensive care. We found that a combination of 12- and eight-hour shifts in the ICU by personal choice was the best model. In fact, the 12-hour shift attracted staff to work in the unit.

**Senator LEES**—Yes. That is what I have heard elsewhere.

**Ms Paris**—We have actually extended that to one of the ward areas as well on the same basis. It is nurse initiated. If the nurses want to do it, I think that you can actually manage it.

**Senator LEES**—Just to aged care, you mentioned visits. In a couple of nursing homes that I have visited lately, one in particular in South Australia, they are looking at this issue of paperwork and looking at developing computer programs, computer modelling. Is that something that you have investigated, just looking at the amount of repetition and just getting base case notes on a particular patient that each day are upgraded, updated, modified, or whatever?

**Mr Shaw**—Yes, most of our larger facilities certainly make use of that. The auditors, if you like—the accreditation agency and the RCS validation teams within the department—insist that the notes be signed and so forth. So it cannot be entirely computerised, unfortunately. That is one of the problems with overdocumentation.

**Senator LEES**—We need some details on this as we work through some of the barriers to nurses. I must add very quickly, anecdotally, that one of the nursing homes has actually done a deal between some nurses who did no paperwork and another who loved the computer and would sit there all day. I guess that it is a problem, though, that we have to deal with. Also, agency nurses would not work in nursing homes because of the amount of paperwork.

**Mrs Toohey**—Can I just make a comment on that? I think what we also need to recognise is that many of the staff in our nursing homes, particularly in the metropolitan areas, are from a non-English-speaking background. So their computer literacy skills as well are not real crash hot, even including our registered nurses. I am not going to pay a registered nurse to sit at a computer all day. I am paying a registered nurse to actually provide clinical care. The Department of Health and Ageing's validators for the RCS do not like computerised care plans. They knock us back constantly on computerised care planning.

**Senator LEES**—That is what we need to know. I am more than happy to have any more evidence that you have got on that area.

**Ms Hatfield Dodds**—Can I just add very briefly that, given that our frame is the best interests of the older person we are engaging with, our perspective would be that the overdocumentation really focuses you on quality of care, which we would say is necessary but not sufficient. We would really like to get quality of life for residents on the table. So with the issue, for example, of using agency staff, there are financial and resource issues there. There are also relational and quality of life issues for residents.

Older people actually like seeing a constancy of relationships in their life. The agency that they are living in, the facility that they are living in, is their home. The people who are visiting them are their family. Eight per cent of residents in some of our Sydney agencies have no regular contact with family. That is nobody coming to visit at Easter, Christmas or whatever. When we are moving to a situation where we are using lots of agency staff and having a high turnover, we are getting residents who do not even have relational consistency in their life. I think that quality of care, yes, is important but quality of life is surely a benchmark that we all ought to be shooting for.

**CHAIR**—Did you want to say something here, Mr Sullivan?

**Mr Sullivan**—No, I was only going to support the last comment about the fact that assessors and validators do not support computer reporting. I think that even though some people would see it as the state of the art, the way to move, it is certainly not the favourable way of the regulators.

**CHAIR**—To each of you, who fills out documentation in aged care? The manager? The RN? The EN? The unqualified carer? Or some other person?

**Mrs Toohey**—A mixture of all. Predominantly, it is the registered nurses and the AIN in nursing homes.

**CHAIR**—AINs?

**Mrs Toohey**—Assistants in nursing.

**CHAIR**—A wonderful new set of words, thank you.

**Mrs Toohey**—And in low-care environments, it will be the untrained care workers who do the majority of the documentation.

**Mr Shaw**—In low care, there is no necessity for a registered nurse to be on duty, you realise.

**CHAIR**—But there is a requirement for documentation?

**Mrs Toohey**—That is right.

**CHAIR**—If you could provide to the committee some further information, following what Senator Lees was saying, it is absolutely critical. It has been a constant complaint all through this inquiry that the amount of documentation in aged care is the reason that we have major problems: who wants to get to be a nurse EN or RN if you have to spend your time filling out paper.

**Ms Hatfield Dodds**—You are asking for stories or examples?

**CHAIR**—I am probably basic enough to say: send me a copy of the documentation and give me a list of how many people have filled this one in. It seems to me that, since I have been following aged care, as remotely as I can, the documentation has grown, or else people are just seeing it with bigger, stretched eyes—and it seems worse. It is consistently given in evidence as a major problem. If that is the case, if this is said to be one of the reasons why we are having a nursing shortage in aged care facilities, this committee needs to know that. We need to have a look at what is real about it. I would love, Ms Dodds, if all of the nursing requirements to fill in paper were removed, whether all of your nurses would stay in now that they had to only care. That is just mean of me to put that.

**Mr Shaw**—We would love to put that together. Do you have a small truck to pick it up?

**CHAIR**—If that is truly the case, yes, we need a truck.

**Senator LEES**—I think that we need documentary evidence and evidence from you that talks about the number of minutes or hours it takes per patient per day—some idea of, say, your average eight-hour shift in a nursing home, what percentage of that is actually in what I would describe as urgent medical care, the things that you have to do for the patient, in an eight-hour shift. Is it 20 minutes on paperwork or two hours? Then finally, what time is left over for general patient support and quality of life issues in terms of actually having time to sit and have a cup of tea with someone.

**Mr Shaw**—Very little.

**CHAIR**—We are seriously trying not to make you write theses. It is more dot points.

**Mr Shaw**—Yes, we heard that.

**Ms Hatfield Dodds**—That stuff is dear to our heart. We would love to let you know.

**Mr Shaw**—And we can get the draft *Hansard* to document exactly your questions?

**CHAIR**—Absolutely. There is no need to have that—

**Senator LEES**—Would anyone else like to join in?

**CHAIR**—There is no need to have that to us before Easter. However, it has got to be here next week. We have got a couple of weeks at least for you to provide that as you can and sensibly. Truly, we do not want a full thesis. I want to go back to your bonded rebate, which is everything new is old again or the other way around. Have you discussed this with nursing groups outside of your own lot?

**Mr Roff**—Not in any detailed way, no.

**CHAIR**—How have you been discussing this and with whom?

**Mr Roff**—It was an idea that actually came out of our own nursing task force, which draws on directors of nursing and others from throughout the private hospitals sector across the country as a method to overcome that very serious problem of the massive exit rate from the profession in the very early years. We have subsequently discussed it with the Department of Health and Ageing, with the minister and, as I said, we have also lodged a submission with the Treasurer in the context of the budget.

**CHAIR**—Have you got any sense of what the government's response is? We are not asking you to leak secrets.

**Mr Roff**—My understanding is that it is being considered in the context of the budget.

**CHAIR**—Can I ask: have you actually spoken about this idea with the other witnesses here today?

**Mr Roff**—I think I may have mentioned it to Mr Cormack a couple of weeks ago.

**CHAIR**—Is it something you will propose with them or is it a patented initiative?

**Mr Roff**—No, I am more than happy to garner support from as wide a range of interests as possible.

**CHAIR**—Do you have any sense that there is value in nurses being attached to an institution and owing loyalty to that, as in, 'I'm an RPA nurse. I'm a St Vinnie's nurse. I'm a Uniting nurse,' as apart from, 'I've done most of my work at the University of Canberra'?

**Mr Shaw**—From our experience, that is how our facilities—those who do manage to attract staff—attract the staff in a difficult climate; because there is that brand loyalty, if you like.

**CHAIR**—So for a small percentage there is a brand loyalty, but the large percentage are not being kept by that? If you had a bonded rebate, that is effectively a way in which you keep people within the ambit of the institution, is it not?

**Mr Roff**—No, I am not talking about attaching it to a particular institution, just within the hospital setting. So provided they are employed in a hospital during that period they would qualify for the rebate.

**CHAIR**—So you are actually trying to offset the contribution of the HECS charge as a factor turning nurses away?

**Mr Roff**—Yes.

**CHAIR**—But they can carry their bonded HECS asset with them to other institutions?

**Mr Roff**—Yes.

**CHAIR**—So that does not do anything about loyalty. Does anybody else want to talk about brand loyalty?

**Mr Cormack**—In relation to the brand loyalty issue, there was some evidence given earlier that I overheard in relation to nursing growing into the status of a profession. I think the notion—and I do not want to go down that path too much of brand loyalty and, 'I am a St Vincent's nurse', or a whatever nurse—is very much related to the growth of academic rigour and presence that is associated with those sorts of institutions. I do not think it is simply a matter of creating a brand that goes with an institution; it is what makes that institution valuable. The teaching and academic environment and the linkages that they form is how you get brand loyalty in, for example, medicine, where there is very strong brand loyalty with where people trained and the teaching hospital they are attached to. So I think it is a good idea, but I

think it is something that would take a long time and it really develops with the growth of academic knowledge that is owned and developed by the nursing profession itself in institutions in which that is developed.

**CHAIR**—I have grown up knowing this was a nursing profession. I am terribly interested to discover that it might be about to become a profession. I have always thought of nursing as a profession. I assume everybody else does?

**Ms Paris**—Absolutely.

**Ms Hatfield Dodds**—In relation to some of those comments about brand loyalty, I completely endorse them. I think there is another pathway into loyalty to an agency or a brand, if you like, which is a relational one. The experience of agencies in our network is that staff tend to stay in a facility when they have built real relational links with residents. In terms of aged care, one of our best predictors for longevity of staff in a facility is their relational links. The issues around the amount of time—the leftover time, if you like—that staff actually have for that quality of life interaction with residents is not just about quality of life for residents; it is around retaining staff.

**CHAIR**—I wanted to ask about the capacity for nurses to have clinical experience in your institutions as apart from the large public institutions. One of the complaints regularly put to us is that a lot of nurses are leaving the profession in their first year out into hospital when, to quote a lovely British colleague, they are gobsmacked when they hit the ward. Some places are already increasing clinical experience in the undergraduate years. It seems to be an important point. But we are told that there are not enough clinical experience places for students. Are people seeking your institutions for placement for undergraduate clinical experience?

**Mr Shaw**—Yes, a number of our institutions have entered into formal memorandums of understanding with schools of nursing to provide that experience during the course, and it works. That is part of building up brand loyalty.

**Ms Miller**—Yes, we provide training opportunities, but it is still the amount of clinical exposure that the undergraduates have that is the problem. All of a sudden, on day one as a graduate they are faced with the responsibility of carrying a patient load. That is a little overwhelming, because they do not have that exposure during their course.

**CHAIR**—So you do have undergraduate students

**Ms Miller**—We do provide that for undergraduates. But you are talking about a first-year student who has had 30 hours clinical placement.

**Senator LEES**—In their whole course?

**Ms Miller**—For their first year as a student nurse. We have recruited student nurses and they have had 30 hours in their first year of training.

**CHAIR**—And that is provided how—a block of two weeks?

**Ms Miller**—There might be someone better placed to answer that, but that is their total hours that they have given us.

**Ms Paris**—We actually do the clinical placements as well, as do most hospitals. But one of the challenges that seem to be occurring now is the fact that the universities, when they send their students to the hospitals, provide another word for you—a facilitator. That is a university employed person, and they are becoming harder to fund. So they are having problems. We are willing to provide the space and the experience for them, but they need to send a facilitator along, and that is where some of the issues are arising, certainly in New South Wales. I do not know about the other states.

**Senator LEES**—So the university cannot afford the time for the lecturer, clinical supervisor or whoever?

**Ms Paris**—Yes.

**CHAIR**—Is it time out or the salary?

**Ms Paris**—It is the salary, as I understand it; that is correct.

**CHAIR**—Do you have preceptors, assistants, supervisors or tutors? What is the going word for your lot?

**Ms Paris**—Yes.

**CHAIR**—You are into preceptors?

**Ms Paris**—Preceptors. You could say ‘mentors’. Somebody even just uses the old-fashioned term of ‘buddy’: we will ‘buddy you up’ with somebody else.

**CHAIR**—Please. It may be old fashioned, but it sounds extremely American. I will stick with ‘preceptor’.

**Mr Shaw**—It could be worse; it could be ‘mate’.

**CHAIR**—In my day they were ‘tutors’ and you knew what they were supposed to be doing. But I am so old it does not matter. Do you pay these preceptors or does the university?

**Ms Paris**—No. They are actually part of the normal work force award. They are a registered nurse, a clinical nurse specialist

**CHAIR**—Have you ever offered to provide that kind of person to look after undergraduates?

**Ms Paris**—We do not have that sort of budget.

**Ms Miller**—Most of the clinical educators look after the graduate nurses, and they are employed by the hospitals.

**CHAIR**—Those are questions we must put to universities, I think. Senator Lees?

**Senator LEES**—I was just looking at some of the recommendations in other submissions. You touch on the number of hours that nurses have had hands-on experience. There have been some suggestions that we need an intern year—something similar to what doctors now do, with payment, which is where all of this ends up hitting the rocks again. Do you see a role for an additional period where these nurses would be paid, not at the same rate as a fully registered nurse but where there was still some direct support for training maybe for six or 12 months after they have formally finished what is now recognised as the course?

**Ms Miller**—The graduate nurse program really meets the intern year and they are paid as a registered nurse. It would be in the interests of the private hospitals definitely if there was an intern year at a lesser rate than it currently is.

**Senator LEES**—So at the moment they are paid at a full—

**Ms Miller**—Full registered nurse rate as a graduate.

**Senator LEES**— Even though they are only still learning basically?

**Ms Miller**—Correct.

**Mr Roff**—My understanding is that—and perhaps Mark will correct me if I am wrong—in a number of states there is actually a subsidy that goes to public hospitals to support the graduate nurse program, whereas private hospitals have to meet that cost out of their own pockets, essentially.

**CHAIR**—One other thing: if this is what Senator Lees asked you and I did not quite understand it, I beg your pardon and don' t answer it; but one of the other things we have is that one way in which some people are trying to increase the clinical experience of undergraduate nurses is for those nurses to work in hospitals during their university student vacation. They are then paid at a lesser rate and they are to some extent precepted by the tutor, matron, whoever. The main problem I have had told to me about why this does not work is that you get much more money at Kentucky Fried Chicken.

**Senator LEES**—Fact: you do.

**CHAIR**—I wondered if all of you actually have students getting clinical experience as part of the paperwork course during university holidays.

**Ms Paris**—Yes.

**Mrs Toohey**—Yes.

**Senator LEES**—Say they are just about to head into third year university: are they paid at an enrolled nurse rate or—

**Ms Paris**—Assistant in nursing.

**Senator LEES**—Could we just have some idea of what that is per hour—just an hourly rate?

**Mrs Toohey**—It is about $11.50 an hour.

**Ms Paris**—It is more than that in the acute sector.

**Senator LEES**—$11.50?

**Ms Paris**—It is probably around $13, $14 an hour in the acute sector.

**CHAIR**—And $20 for Kentucky Fried Chicken?

**Senator LEES**—If you are a supervisor it is about $16 or $17.

**Mr Shaw**—Operator, yes.

**CHAIR**—I want to turn to the dependence on agency nurses. I thought, Mr Sullivan, you were telling us about $200 a week. When we were in Western Australia—was it you telling me that?

**Mr Sullivan**—I made a mistake. It is $200 an hour.

**CHAIR**—I was just thinking: if you were going to get it for a week, you are very, very well off, because the nurses we heard about in Western Australia—

**Mr Sullivan**—I think I went weak when I said it.

**CHAIR**—We did not believe it. But it was quite shocking to discover that agency nurses are coming from Western Australia in a week or two-week block to Victoria, for example, because they were actually able to get 45 per cent—that is all—of a $200 to $250 per hour fee. It is called money for jam for the agencies, because they are charging you people $250 an hour and collecting $55 only for getting the nurse's name and address and phone number. Well, they would probably say they did a bit more; but I would be interested to know what has been the impact on your institutions of the Victorian government's decision to completely stop it.

**Mr Roff**—I can perhaps provide some anecdotal evidence from one hospital. Although it is very early days, and this hospital has been quite innovative in terms of the measures it has undertaken to recruit staff nurses and this was a report I had earlier this week, they have noticed a decrease in their reliance on agency staff in the last week or two.

**Mr Sullivan**—I suppose the other side of that, in the case that I evidenced in the introduction when they did go to an agency for $200 an hour for that nurse, why did they go? The actual facility was surrounded by six public hospitals, and they had to try to get a nurse attracted across. They obviously got someone for the day very quickly. With the situation changed by the Victorian government, they still struggled to find someone to come from the acute sector to the residential care sector, and that is the disparity issue. That is when I think it is quite marked. We all agree that there needs to be an intense examination of the conduct of an agency on many levels. It is on the level of competition policy, which I know is already being pushed, but it is also on the level of literally the capacity that agency then has to threaten the viability of smaller residential aged care facilities on their budgets. This is ridiculous. As we said in the introduction, all of us agree that there needs to be a just wage outcome for nurses, and you could argue that we have not got there yet. I do not think any of us agree about the way this is being used by the agencies to cream.

**CHAIR**—Thank you. What conversations happen between you to try to address situations like: the wages and conditions are better for nurses in the public sector; we have different conditions; it is not easy for people to lift up their super or whatever and walk across to a private hospital next door? Is there any discussion going on at all?

**Mr Shaw**—Yes. Certainly Catholic Health and UnitingCare Australia are two of the 21 members of the national aged care alliance, which the Royal College of Nursing and the Australian Nursing Federation are also members of. We are working very cooperatively together to seek to address all of these issues in aged care.

**Mr Sullivan**—It is important, I think, in answering that question not to forget the different funding models between public and private hospitals here. You cannot leap over that and say simply that it can be discussed between hospitals or associations about a solution. I mean, the public hospital sector has its hands tied on a budget arrangement. We in the private hospitals sector are primarily funded through insurance models. The funders, as we said in the introduction, have as much responsibility in this debate as the management level, because you cannot go with inflationary pressures on wages when your hands are tied on what your recurrents are. I think that is part of the issue that it would be great to see the Senate reflect on.

**Mr Shaw**—Can I just add that I would not want us to finish without getting into the record that certainly from our experience the crisis is most acute in rural and remote areas.

**Senator LEES**—That was a good introduction to our next witnesses.

**CHAIR**—It is indeed. Can I ask each of you if you could provide for us briefly the percentage of your nurse work force that is agency or has been up until recent decisions by Victorian governments?

**Mr Roff**—I have had reports that it can be up to 35 per cent of total nursing staff.

**CHAIR**—And a 20 per cent minimum mark-up?

**Mr Roff**—No. For example, in New South Wales the minimum mark-up we can find is 63 per cent. The highest is 126.

**CHAIR**—Could you provide to the committee some of those figures, like what is your average figure of use of agency nurses and from state to state what is the mark-up? That would be very, very useful for us, indeed. Last question: how do each of you talk to universities, if at all? Do you want the committee to recommend that all those things that you have been talking about happen? It is really like: how do we make the connection? At the moment it seems that there is a health system and an education system and really the meeting between the two is pretty small and fragmented and they are not good at listening. Each area is particularly concerned about funding restrictions. Do you talk directly to your allied educational institutions?

**Mr Cormack**—We certainly do. I think it is interesting that some of the best arrangements that have been put in place have taken place in those states where there is a small number of nursing schools, such as Tasmania and the Northern Territory. So a lot of it is taking place on an institution by institution basis rather than, for example, a national curriculum or a national standard for the content of nursing undergraduate programs. So, yes, there is a lot of discussion going on, but at the end of the day it is voluntary, it is consensual, and it does not have to happen.

**Mr Sullivan**—I think that is exactly right. It is like a national mental health strategy. We all buy into it, but who cooperates are those with the commitment.

**CHAIR**—Everybody has told us that there is a major nursing shortage, and it goes to recruitment of young ones, although there seems to be on evidence a contradiction there, because there are more people applying to do nursing than any education institution has places for. There is a very big drop-out of first year out into practice nurses, and there is a very big challenge of recruiting people back into nursing after they have moved out for family or other jobs or travel or whatever.

It would seem to me, though, that one of the other reasons has been the interface between education and the curriculum sometimes being quite unsympathetic. But it seems that there are almost no mechanisms for those responsible for work force and nurses to be seriously able to effect changes in education. I gather from a number of your submissions that a chief nurse in the department or the government—state, territory and federal governments—is a good thing so that at least there would be a person who might be able to be a focus for a lot of this evidence. I take it from what you are saying, Mr Cormack, that you are not against a national strategy.

**Mr Cormack**—Absolutely not. We do have a mechanism for doing this through AHWC. I think one of the problems with AHWC is that it recommends things that nobody has to do. I think that if you cannot actually force people to meet work force planning targets, at the very least you can put in place a performance reporting arrangement that covers the stakeholders, which are the federal government, the state government, the industry, professional bodies and training institutions, and make that accountable each year so that we do not get into the circle that we always get into with these things, which is about blaming somebody else. There is not a national reporting framework for it.

**CHAIR**—Lastly, would each of you, or collectively, like to be able to talk directly to educational institutions and say, ‘The course is missing our needs’?

**Ms Hatfield Dodds**—Yes.

**Ms Chin**—Yes.

**Ms Paris**—Yes.

**CHAIR**—Do you have a way in which that could happen?

**Mr Shaw**—It varies from state to state, from institution to institution.

**CHAIR**—That is what is there now. What would you recommend? Should it all be through the chief nurse and into universities, or should you collectively take your case?

**Mr Shaw**—That would be nice, but we might need a magic wand.

**CHAIR**—I think this is one of the very big problems that this committee faces.

**Mr Shaw**—Certainly, the committee can help to get these issues onto the public agenda.

**CHAIR**—That is certainly something that we are pretty aware of. There are two big departments, if not three, and we have to go across that. It certainly seems that we have not quite found the way yet. What about via the Australian Nursing Council, as boards have to approve courses?

**Mr Cormack**—I think that would be a useful start.

**Mr Sullivan**—In the end, though, it is about who ultimately is responsible for ensuring that the system is well staffed. As I said at the beginning, ultimately most of the services that we are talking about here have a heavy component of Commonwealth funding. There is a leadership role here that you are asking of us that maybe is not the appropriate place to go to.

**CHAIR**—I think that is a very important point. The interesting thing is that, when we talk to universities, they say a not dissimilar thing—that the real question in the end is adequate funding to meet the work force needs. But we are much assisted by your generous contribution this evening.

**Senator TCHEN**—Since what is said at this hearing goes in *Hansard* and becomes a public record, I have some concern that some of the asides, particularly about Kentucky Fried Chicken, might be taken out of context. I want to point out that the Kentucky Fried Chicken client server performs a more important function for the majority of the population than a nurse, especially since if he or she does not perform his or her function properly, the client might be looking for a nurse. I do not know about Kentucky Fried; I do not know whether there is a Colonel Sanders university, but certainly there is a McDonald’s university, so they are tertiary

qualified, too. I do not want to give the perception that we are classifying the type of work that people do and the contribution that they make to the community.

**Ms Hatfield Dodds**—We would like to submit a report from the Lucan Care facility. It is called *My heart on my sleeve*. It is a story window into aged care facilities.

**CHAIR**—Thank you. I do not have to tell all of you that once a report is written, with recommendations, that report is then in the public domain and it belongs to the community, the witnesses and everybody else, in order to lobby.

[7.06 p.m.]

**GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance**

**CHAIR**—Welcome, Mr Gregory, representing the National Rural Health Alliance. The committee prefers all evidence to be given in public, but if you wish to give evidence in camera you can ask to do so and we would give consideration to your request. The committee has before it your submission No. 800 and we also have had provided to us your opening statement, which I would now seek leave to incorporate. Is it the wish of the committee that the statement be incorporated in the transcript of evidence? There being no objection, it is so ordered.

*The statement read as follows*—

**CHAIR**—In the interests of time, Mr Gregory, you might like to highlight the points in that and then field some questions.

**Mr Gregory**—Thank you. May I first acknowledge the absence of Nigel Stewart, Chairperson of the National Rural Health Alliance, who is a paediatrician working in your home state, Chair, in Port Augusta. He would have liked to have been here. Can I also make the rather facetious but, hopefully, meaningful comment that it is significant that the rural and remote advocate is here alone. It is a very lonely job being a remote advocate. That is the nature of remote areas. Had I worked for a city organisation, no doubt I would have been surrounded at relatively low cost by several members of my board. As it is, I am here alone.

Can I also quickly recognise the 21 member bodies of the alliance on behalf of whom I am speaking and, in particular, those three that are nursing bodies in their own right—that is, AARN, the Australian Association of Rural Nurses, the ANF and CRANA, the Council of Remote Area Nurses of Australia. I also want very briefly to acknowledge Joan Lipscombe, the consultant who worked on this submission for us many moons ago, it seems now.

I will highlight a couple of points from the introductory statement which I have provided to you. I thank you for incorporating it. The challenges facing the nation with respect to the rural and remote nursing work force remain very high on the alliance's own agenda. In terms of this committee's inquiry, the alliance's main general proposal is that the national government should be playing a leadership role in the matter. On this front, there is a modest amount of good news—and we welcome the good news—which includes the so-called CURRNS, the Commonwealth Undergraduate Rural and Remote Nursing Scheme, the re-entry scheme, as well as the continuing postgraduate scholarship scheme. All three are modest but very useful. We naturally support them very strongly and hope to see them enhanced and expanded over the years. The main reasons for the Commonwealth's leadership role, should there be any doubt, are spelled out in our submission, but briefly they are that the Commonwealth has a sole and unequivocal responsibility for higher education, migration and the aged care sector. I want to read, with your permission, two paragraphs which appear on page 2:

> Such is the Alliance's commitment to this issue that a project on the matter is likely to be the most significant single piece of work undertaken by us this calendar year. The proposal for a national summit on rural and remote nursing first arose as a priority recommendation from the 6th National Rural Health Conference. The three nursing bodies in the Alliance are the Australian Nursing Federation (ANF), the Association for Australian Rural Nurses (AARN) and the Council for Remote Area Nurses of Australia (CRANA). These three have taken the lead in work on the Summit which is to be held in Adelaide in July. Such is the interest in the event that those three have been joined by no less than five other national nursing bodies: the Australian Council of Deans of Nursing, the Australian Nursing Council Inc, the Congress of Aboriginal and Torres Strait Islander Nurses, the Chief Nursing Officers—

not strictly a nursing body but a group of individuals—

> ... and the Royal College of Nursing Australia.
>
> This group of eight national nursing organisations, with the strong support of the Alliance as a whole, and its 18 other Member Bodies, is currently negotiating with Governments through AHMAC and the Australian Health Workforce Officers' Committee about collaborative work on the proposed Summit.

We have done a lot of work since making the submission to you last June. I want to mention very briefly some of the issues which it is now clear will emerge in the work we continue to do,

and this is not a comprehensive list. They are: the shortage of senior nursing managers; questions of remuneration and benefits, particularly in so-called hard-to-recruit areas; an adequate level of resources, for example for equipment, and of professional support systems; ensuring that all nursing undergraduate curriculums have adequate reflection of rural and remote practice and relevant rural and remote content; and strong support, as I have already intimated, for the expansion of the existing modest Commonwealth scholarship schemes for nurses.

As can be seen, the alliance is, as it were, putting its money where its mouth is and working hard to ensure that people in rural and remote areas have access to a sufficient number of nurses and that the nurses are highly regarded, well remunerated and well supported. When these three conditions apply, there should be little trouble in recruiting and retaining nurses for non-metropolitan areas. If the conditions do not continue to apply, the situation will remain as described in the alliance's written submission. Thank you.

**Senator TCHEN**—Mr Gregory, you have presented a large shopping list of recommendations—40, in fact. Given that some circumstances might have changed, have any of those 40 recommendations already been implemented?

**Mr Gregory**—Not to my knowledge, although as I have said there has been a very positive, modest start made with undergraduate nursing scholarships, the so-called CURRNS.

**Senator TCHEN**—In that case, can you give us some indication of what, out of those 40, you see as the main priority areas?

**Mr Gregory**—I think the best thing to do is to refer you to the dot points in my opening statement, because that is, if you like, a restatement of the priority recommendations and comes from the work that we have undertaken in the alliance and with five other national nursing bodies since we made the submission to you nine months ago.

**Senator TCHEN**—Okay. So the dot points are not actually ambit points but are actually specific.

**Mr Gregory**—There are eight of them.

**Senator TCHEN**—In that case, I can move to the next question. Can you expand on your suggestion that the government should consider innovative approaches to reduce the burden of HECS on nurses intending to practise in rural areas. That is your recommendation 12. What do you mean by 'innovative'?

**Mr Gregory**—I think what we mean is that it would be, as far as I am aware, new. What we propose, of course, is differential in the sense that it would be in favour of our constituency. We make no apology for being a particular rural and remote advocacy organisation. Therefore, what we are proposing is that there could be a HECS reimbursement scheme for service in rural areas such as there is for medicine.

**Senator TCHEN**—Is there one for medicine? I am sorry; I am not sure.

**Mr Gregory**—Yes, there is.

**Senator TCHEN**—There is a HECS reimbursement scheme for medicine?

**CHAIR**—The wonderful thing about witnesses is that they are very reliable.

**Senator TCHEN**—I was under the impression that Treasury defends the HECS agreements like it defends everything else.

**Mr Gregory**—There is in existence a HECS reimbursement scheme for medical graduates. It is true to say that it is still as yet young. I am not sure that it is actually in operation, but it does exist. The department of health is certainly working on its implementation.

**Senator TCHEN**—Good. You also suggest a number of approaches to encourage young people from rural areas to become nurses, which is recommendation 13, and you have quite a few dot points there. All of this costs money. How much additional expenditure would be required to fund all of these initiatives? Can you also indicate whether you think some of these initiatives are more important than others.

**Mr Gregory**—The word 'crisis' is used willingly and intentionally, because the situation is so serious. As one of the recent witnesses that I was fortunate enough to hear said, there is a serious national situation overall and the worst of it is experienced by rural and remote areas. I cannot answer with any degree of accuracy at all your reasonable question about how much it will cost. I suppose all the alliance is seeking is that we make a start and in that start the Commonwealth government plays a greater role than it has played over the last several years, although I say again that things are moving in the right direction. We are encouraged. We do not have a dollar figure. I think it is true that the department of health has costed HECS reimbursement fees for a range of health professionals, and even the differential application of that proposal only to those who serve in rural and remote areas would cost substantial amounts of money. But we do not resile from that substantial price tag given the seriousness of the situation. It is very serious. We think it is difficult to establish aged care places in rural areas, but when that is done with some limited success and then the facility is not able to remain open 24 hours a day because of the absence of nursing, that is one example of how serious the situation is.

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

**Senator TCHEN**—Thank you, Mr Gregory. That is admirably and persuasively argued, because reference committee inquiries always face the problem eventually of whatever we recommend the government coming back and saying there is no money, but I think that perhaps the secretary can take your arguments into account. Finally, I refer to the problem of attracting and retaining indigenous people in nursing. This is contained in your recommendation 14. Your

recommendation suggests that we look at the recommendations of the Island Nursing Forum. Can you expand on that or be more specific?

**Mr Gregory**—It is clear, isn't it, that it would be a wonderful contribution to Australia's most serious social problem—that is, the status of health of our indigenous people—if we were to succeed in getting better numbers of indigenous people into all health professions? So it is an eminently worthwhile challenge, but of course we know that it is also a very complex one. It goes to general questions about educational attainment. We know that retention rates amongst Aboriginal people and Torres Strait Islanders are very low. So the answer to the question specifically that you raise, about how to get more indigenous people to become nurses, is, I suggest, a very complex one, the answer to which is similar to the general one about how we get more indigenous people into all health professions. We need to improve education retention rates amongst those peoples. We need to recognise the cultural differences. We need to provide differential policies relating to planning styles, systems and curriculums, and I am sure there are plenty more. I am sorry that we have not spelt out in more detail the precise way in which we think that we as a nation should go about that. But, clearly, it is a very ambitious but, to the extent that we might meet it, a very, very important aspiration.

**Senator TCHEN**—I understand that there has been some success in attracting Aboriginal and Torres Strait Islander people into medical courses. Are there the same trends in trying to attract them into nursing?

**Mr Gregory**—My understanding is that it is limited and there is still a problem with retaining them. Most people know more about this particular question than I do. We are not making progress in any leaps and bounds with that, even in medicine, I am sure.

**Senator LEES**—I would like to begin by congratulating you on the way you set out all the recommendations at the front. The committee likes to see where we are heading with some options. I am just wondering if across Australia from state to state you have looked at which universities are actually offering rural experience, perhaps as part of a core curriculum which I would suspect are very few but at least as options in the second and third year?

**Mr Gregory**—I cannot say, I am sorry.

**Senator LEES**—I think we are heading towards the trouble that we are going to have to survey universities because, as we heard with earlier submissions, aged care is another issue where some universities offer no placements. In your recommendations I cannot find any reference to a couple of other issues. Looking at accommodation in rural areas, do you see that as a role perhaps for state government to consider?

**Mr Gregory**—It certainly is an issue. Some of the constituents of the alliance say that it is a major issue. I understand, as we all would, that some of the readily available accommodation that might have been used 20 years ago is now closed—I mean the nursing accommodation that existed—and there is great pressure on accommodation. But it is not the only issue, of course, in getting greater numbers of successful rural placements. There is also the support. There is great competition, just like doctors, because the mentors or potential mentors are so stretched and so busy. There is competition, as I understand it, between universities for these services of good

mentors and there is also the cost of getting the students out there and giving them some support while they are there. But accommodation certainly does arise as an issue.

**Senator LEES**—You have mentioned in your recommendation 27 the scholarship scheme and Senator Tchen was touching on this—whether you have the John Flynn scheme for medical students. You are looking at 300 scholarships a year. The government has already put in place the 100 rural nursing scholarships a year. Can you give us any feedback on how that is going? I know there is a group of rural students now who are getting together to help support each other. Are you actually seeing these rural students out in rural practice very much through your organisation?

**Mr Gregory**—Let us be clear now: the John Flynn model is not the same as the CURNS.

**Senator LEES**—No, we have a hybrid. You are saying we need another 300 under the John Flynn model. But of the 100 that we are already now training in our universities, could you give us any feedback on how that is going?

**Mr Gregory**—It is going well. Of course there were more than 100. In fact, money was found, which was good news again, for another 30. As I understand it, there were 130 plus 10 specific ones for indigenous people. The criteria are the same as for the RAMUSS, the Rural Australia Medical Undergraduate Scholarship Scheme; that is, they had to be people who come from rural or remote areas as defined. The money is the same as for RAMUSS. The alliance is not directly involved in its administration; the Royal College of Nursing Australia is doing that. I know that there were significantly larger numbers of applicants than places. So clearly it is something for—

**Senator LEES**—So there is room to expand that?

**Mr Gregory**—Absolutely. All member bodies of the alliance would strongly support such an expansion.

**Senator LEES**—I am just looking at the perceived need in rural areas for group practice of doctors, nurses and allied health professionals. Do we need to see this scholarship system perhaps extended further into areas such as pharmacy, maybe physiotherapy and other areas where we are not able to at the moment attract enough professionals?

**Mr Gregory**—The short answer is yes. I would remind you again that there are a small number of pharmacy scholarships being provided, again through the Commonwealth Department of Health. The idea you mention is one of the most exciting, I think. I say 'most exciting' advisedly because, when you meet with the people in the National Rural Health Network, as you have done, which is the student undergraduate medical and health clubs, there is a great sense of excitement because they are young, energised and committed.

You refer to the possibility that in our placement activity for all health professionals we can actually undertake the placements as a group. That is a wonderfully sensible idea and an exciting idea, but of course it would require a large amount of collaboration across the board. At the moment, as you well know, there is no national collaboration of medical vocational

placements; in other words, there is competition between medical schools for the best mentors and the best places for their vocational placements. But I think what you have averred to there is a very sensible, if ambitious, proposal that we should be starting to develop the multiprofessional health team at the very earliest stages.

**Senator LEES**—At the training stages?

**Mr Gregory**—Yes. And we can do that through placements. It would be wonderful if we could say, ‘Here is Wagga Wagga,’ or even somewhere smaller, and, ‘Here is a facility which will enable the pharmacy student, the nursing student, the physio student and the medical student’. Of course, we need to give credit where credit is due. We are making some good progress through clinical schools, the university departments of rural health and the rural health training units. Arguably, in the health sector, compared with other sectors, we are doing quite well in locating physical and intellectual resource capacity in the regions. So we do seem to be developing a good basis with the university departments of rural health, the clinical schools and the rural health training units, but there are concerns still about the extent to which they are multiprofessional. They are still largely funded by and dominated by medicine.

**Senator LEES**—I have just one final question. I know that time is slipping away. Looking at arrangements of rotation, sometimes one of the reasons nurses will not move out is that they cannot quite see their path back again. It is the same thing with doctors. I guess they are looking at some sort of a structure where they know that the sort of support will be there when they want to move back into, say, a major regional centre or a city. Is there any need for us to look at any sort of a rostering system where perhaps the state government is able to work through some of the major hospitals in actually placing nurses in some of the smaller hospitals and saying, ‘Okay, in two years time your place at Royal North Shore’ or wherever ‘is free again if you go out and do two years at Walgett’?

**Mr Gregory**—I am sure you are right. One of the things that it puts us in mind of is the fact that an organisation such as the one I work for, which is passionately advocating for rural and remote constituents, has to remember that we are part of one society. One of the reasons that people will not go is, as you say, that they fear they may not be able to get back. Sydney house prices, for one thing, may be a significant disincentive. So I am sure you are right. We have already started to think about this in medicine, of course, in terms of consideration of what ‘sustainable general practice’ means.

If I could finish my answer by saying that some people assert that it is actually even bigger than that, that we should be looking at all health work force issues not in a national context but in a global context. In our submission, and no doubt in many others, you had information relating to the net migration effects. What people are saying is that we have to get away from the situation where we are concerned to manufacture enough good graduates in our country so that everybody who needs a nurse who is trained in Australia has one. Globalisation, which of course to many rural people is a bogy or anathema, has to be seen surely as being something which impacts on the work force as well. I am not sure what it means in terms of what you might want to say as a committee of inquiry, but what it means as a government is surely that the work force planning that we are going to be doing to solve a serious problem like this has to

account for migration in and out and therefore has to have more than a peek at global trends in nurse education.

**CHAIR**—That is certainly something that has come up again and again—institutions or state governments, for example, advertising overseas. Senator West and I visited the people involved with the nurse inquiry in the UK, which I think completed its inquiry a couple of years ago. We were there last July. They were very interested in the number of UK nurses who were going off to work in America and Canada. Australian nurses are going to the UK and the Irish nurses are going around the world, too. It may not be the case for so many other professions, but for nursing at the moment what you say is true. I wanted to ask you a bit about the proposal for a summit. It sounds as though you had three bodies that were interested and, when information got out, you picked up a lot of other support very quickly.

**Mr Gregory**—Yes. It is very encouraging in some respects, as you say, when you look at the list of organisations involved, as I am currently. I think I read them out, didn't I?

**CHAIR**—You did. You spelt them out on page 2 of your statement.

**Mr Gregory**—It is a very impressive group of nursing organisations. They are all committed to doing some things which will lead to action for rural and remote areas.

**CHAIR**—Do you have any government support at a state, territory or federal level?

**Mr Gregory**—At this stage it is somewhere between uncertain and disappointing, I would have to say. The matter has been discussed by AHMAC and has gone recently to the Australian Health Workforce Officers Committee. I have not yet received on behalf of this collaboration of nine national bodies formal advice, but the informal advice is that the states, the territories and the Commonwealth think it is a splendid and important idea and they would like to come. However, it is not at all clear that they will find their way to help us actually run it. If that is the case, it will jeopardise the event.

It seems to us to be a classic case of not understanding fully the real cost of participation by people, especially people that we represent from rural and remote areas. It is one thing to have a great meeting in Adelaide at which there are lots of public servants—and I have strong support for all that public servants can do—but what we are looking at here is a tripartite activity which involves public servants who are involved with nursing, national organisations who are involved with nursing and the community. There is no way that we can have a meeting which involves the last two of those three groups unless we have some support. So I am still hopeful—

**CHAIR**—Are you also writing directly to governments and ministers for health? The process through AHMAC and the Health Workforce Officers Committee is in there, but it does not go up to where the decisions are made.

**Mr Gregory**—We have written directly, of course, to ministers. Indeed, we first raised it with the Prime Minister during the election campaign, because that was the time when the planning was beginning. We wrote to him as a caretaker. So, yes, we have written to ministers. I would have to say that from chief nurses and from the rural people in the health departments there is a

lot of enthusiasm—and by ‘rural people’ I mean the most senior people who exclusively look after rural affairs in health departments, who are keen—

**CHAIR**—Are you planning to write again?

**Mr Gregory**—I think we will have—

**CHAIR**—Writing during an election campaign is likely to be lost in the excitement.

**Mr Gregory**—I am sure we should write again, and I am sure we shall. As I say, the whole exercise will be not exciting but rather disappointing unless we get some support.

**CHAIR**—It is interesting because it is, curiously, extremely apposite to our inquiry. I would be one of those people who would be interested to see it be successful. I am interested that you say that so far you have no strong government assistance from any state, territory or federal government.

**Mr Gregory**—It has been indicated that they would like to come, and no doubt they will send the chief nurses and other policy people. But the question is how people from Tibooburra might get there if indeed the nurse from Tibooburra has something useful to say, as I am sure she has.

**CHAIR**—So this means that you would have to look for sponsors?

**Mr Gregory**—One of the options is to find a sponsor from the private sector, but I suspect that would be difficult.

**CHAIR**—Finally—we are over time and I beg your pardon—do you have any further information about the state of play for Aboriginal and Torres Strait Islander people? You do not have to write a thesis or anything, but perhaps you could point the committee to where we could find more information. It is obvious as we go through the inquiry that there are big gaps. While we know of the problem among the Aboriginal and Torres Strait Islander community—and we will be talking to some witnesses in Brisbane—we are still short on good information. If you had anything further you could send us or a reference that you could point to that might give us some of that data, that could be very useful.

**Senator LEES**—Particularly as your members in rural areas might have more access to some of the rural schools. They might have knowledge of programs within those schools that assist with practical education on the ground or work experience. Schools might be either promoting courses for Aboriginal health workers or looking at enrolled nursing courses. There might be some sort of mentoring process from their communities. Some communities have themselves taken on this role of selecting someone to do an enrolled nursing course. Your members are out there on the ground and this is information we are having trouble getting.

**Mr Gregory**—When you are in Brisbane, I hope that you will be hearing from the Congress of Aboriginal and Torres Strait Islander Nurses.

**Senator LEES**—We might have our questions answered there.

**CHAIR**—We might indeed. We do not want a thesis, Mr Gregory. You have given us a pretty comprehensive submission.

**Senator LEES**—It contains very good recommendations. Thank you for that.

**CHAIR**—Even if there were just a few dot points for other people.

**Senator LEES**—Maybe there is a model that you can just point us to and we can seek some more information.

**Mr Gregory**—Thank you.

**CHAIR**—I apologise again for keeping you. We very much appreciate your being prepared to speak to the committee, because it is much better when we can push our way through the submissions.

**Mr Gregory**—Thank you.

**Committee adjourned at 7.39 p.m.**