Australian Nursing and Midwifery Federation (ANMF)

Response to the Australian Government National Skills Commission - Care Workforce Labour Market Study - Consultation

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Australian Nursing & Midwifery Federation

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Introduction

1. The National Skills Commissioner has been tasked by the Prime Minister to undertake an in-depth study on the existing and anticipated factors that impact the supply and demand of care workers from now until 2050. Stakeholders have been asked for insight and input in relation to the following focus areas:

    2. Workforce observations
    3. Workforce attraction, retention, and development
    4. System settings
    5. Thin markets
    6. Technology
    7. Monitoring framework
    8. Data gaps

2. This submission is the Australian Nursing and Midwifery Federation's (ANMF) response to the Commissioner's request for feedback from stakeholders and refers to the Discussion Paper – Care Workforce Labour Market Study,[1] and associated Terms of Reference.

3. The consultation's Terms of Reference rightly highlights that workers in Australia's care and support sector provide essential services to Australia's most vulnerable people across the aged care, veteran and mental health, and disability sectors. As one of Australia's fastest growing sectors, there must be both greater recognition for the contributions and dedication of this workforce as well as genuine, sustained support and funding directed at rewarding and enhancing their capacity and wellbeing. As the Commission understands, the care and support sector is comprised mainly of women who often work in a part-time or casual capacity. In recent years there has also been an increase in the number and proportion of workers employed via even less secure sub-contracting arrangements (the 'gig economy').

4. The Commission recognises that over the coming years, the growing National Disability Insurance Scheme (NDIS) and ageing population will further increase the demand for workers across the breadth of the care and support sector. Workforce problems across the sector are already apparent, with understaffing and inadequate skills mix particularly prevalent in the aged care sector[3], mental health[4], disability care[5], veteran health[6], and across rural, regional, and remote areas. These issues have been known for some time, yet there has been inadequate action by successive Governments to address them. While overall supply of nurses in Australia is currently adequate,[8] the above sectors and contexts do have current shortfalls. Further, extensive overall national shortages are expected within the next four years with an anticipated shortage of over 100,000 nurses by 2025.[9] Additionally, due to global shortages of nurses (particularly in low-middle income countries),[10] the unethical nature of Australian reliance on drawing nurses from in particular, lower-resource contexts, and the closure of international borders,[11] Australia will face a significant challenge in the years ahead to ensure high quality care.

[1] National Skills Commission. 2021. Discussion Paper: Care Workforce Labour Market Study [Online]. Canberra, Australian Government. Available: https://www.nationalskillscommission.gov.au/careworkforce [Cited 3 June 2021].
[2] National Skills Commission. 2021. Terms of Reference: Care Workforce Labour Market Study [Online]. Canberra, Australian Government. Available: https://www.nationalskillscommission.gov.au/terms-reference-care-workforce-labour-market-study [Cited 3 June 2021].
[3] Royal Commission into Aged Care Quality and Safety (2021) Final Report: Care, Dignity and Respect. Commonwealth of Australia.
[4] Foster, K., Roche, M., Giandinoto, J.-A. and Furness, T. (2020), Workplace stressors, psychological well-being, resilience, and caring behaviours of mental health nurses: A descriptive correlational study. Int J Mental Health Nurs, 29: 56-68.
[5] National Disability Service. 2020. State of the Disability Sector 2020. Available: https://www.nds.org.au/about/state-of-the-disability-sector-rep
[6] Parliament of Australia (2016) Mental health of Australian Defence Force members and veterans. Commonwealth of Australia. Available: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/ADF_Mental_Health/Report
[7] A Biggs, Rural health workforce, Budget review 2018–2019, Research paper series, 2017–18, Parliamentary Library, Canberra, May 2018
[8] Australian Government Department of Education, Skills, and Employment (2014-15) Labour Market Research - Nurses Australia. Australian Government. Available: https://www.dese.gov.au/collections/nurses-labour-market-research-reports
[9] Health Workforce Australia (2014), Australia's Future Health Workforce – Nurses Detailed, HWA, accessed 20 January 2021
[10] World Health Organization (2020) State of the World's Nursing. Available: https://www.who.int/publications/i/item/9789240003279
[11] Buchan, J., & Catton, H. (2020). COVID-19 and the International Supply of Nurses. Report for the International Council of Nurses. Geneva: International Council of Nurses. Geneva: International Council of Nurses.

8. We have stated in a number of submissions,[12, 13] particularly in response to inquiries about skilled migration visas, that it is not always a matter of a shortage of nurses, but that graduates experience barriers to obtaining work- such as a lack of graduate programs, poor connection between educational institutions and providers, poor pay and conditions on offer and a preference given to experienced staff over graduates. As noted by the Commission, we anticipate that these shortages will be amplified in the future unless genuine policy and legislative actions and carefully directed funding occur as a matter of priority.

9. The issues raised above must all be addressed to ensure people with the right skills and training are attracted to and are retained in the care and support workforce.

The Australian Nursing and Midwifery Federation

10. The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional,industrial, and political interests of more than 300,000 nurses, midwives, and personal care workers (PCWs) across the country. [14]

11. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, to fulfil their professional goals, and achieve a healthy work/life balance.

12. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

13. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities

Workforce Observations

What observations do you have about the job roles in the care and support workforce?

14. In Australia there are two categories of nurse regulated to practice: the registered nurse and the enrolled nurse. A registered nurse is a person who has successfully completed the prescribed Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited education program and has acquired the requisite qualification to be a registered nurse with the Nursing and Midwifery Board of Australia (NMBA). Registered nurses undertake initial and ongoing assessment of nursing care needs, supervises, and delegates aspects of care to enrolled nurses and PCWs.

[12] ANMF. (2020) Submission to the Department of Education, Skills and Employment in relation to the consultation on skilled migration occupation lists review [Online]. ANMF. Available: https://anmf.org.au/documents/submissions/ANMF_Submission_Skilled_Migration_Occupational_Lists_Review.pdf

[13] ANMF. Submission to the Senate Select Committee on Temporary Migration (2019) ANMF. Available: https://anmf.org.au/documents/submissions/Submission_to_the_Senate_Select_Committee_on_Temporary_Migration.pdf

[14] Personal care workers can be referred to by a variety of titles, including but not limited to 'assistant in nursing', 'care worker' and 'aged care worker'. In Australia, these staff are unregulated in contrast to registered nurses and enrolled nurses. For the purposes of this submission, workers who provide assistance in nursing care within nursing homes and in-home care in the community are referred to as personal care workers.

15. Nurse practitioners are a further category of nurse, however one that builds upon the practice of the registered nurse (i.e. nurse practitioners are registered nurses also). Nurse Practitioners have achieved a Masters level qualification and have significant nursing experience and expertise. Australia should increase the utilisation of nurse practitioners as an increasing proportion of Australia's future care workforce. The nurse practitioner's scope of practice is reflective of their context of practice, where they are working and the education and expertise of the individual.[15] Nurse practitioners provide advanced nursing care and work across critical care, rural and remote areas, mental health, alcohol and other drugs, chronic disease management, primary health care, aged care, and correctional services. They represent a high value approach to managing increasing numbers of patients particularly in relation to costs and outcomes and to the healthcare system through nurse practitioner-led and collegiate models of care.

16. The ANMF notes that the Commission has not included midwives amongst the profession/job roles within the scope of their study. The role of midwives in improving perinatal nutrition, screening for alcohol and other drug use, establishing therapeutic relationships with a woman and families, providing support and resources on issues from post-partum depression to family violence, and minimising birth-related trauma, is essential. The ANMF recommends that the Commission should expand the focus on their study to incorporate midwives and midwifery care as important components to examine. Research consistently demonstrates that midwifery continuity of care models improve maternal mental health outcomes. A recent report estimates the first-year costs (i.e. from conception through to the first year of a child's life) of perinatal depression and anxiety is $877 million, extending to a lifetime cost of $7.3 billion.[16] The ANMF strongly recommends identifying midwives as key contributors to care for women and families and part of the care and support workforce.

17. It is imperative that the care and support workforce has greater and more sustainable capacity and capability to provide high quality care and support to care recipients. This will only be achieved by improving the standing of workers in the sector through improved training, wages, and conditions. The work must be valued by society as skilled, often complex and vital to ensuring the dignity, wellbeing and health of people who access care.

18. Working in the care and support sectors must be promoted as an attractive and rewarding career option and provide pathways for development and skills enhancement leading to better work outcomes. The entrenched view of care work being low skilled and inferior on the basis of being 'women's work' must be overturned. Within the sector, there is a prevalence of part-time, low-hour contracts, and casual work. Many workers are compelled to work over multiple sites and/or for multiple employers to earn a living wage. This has resulted in a fragmented workforce that lacks an industrial voice and is unable to provide consistent quality of care. There are also known risks here in terms of infection prevention and control that have been most starkly revealed during the SARS-CoV-2/COVID-19 pandemic and its impact particularly on the residential aged care sector.

[15] Farquhar, K. (2014). Expanding the scope of practice of the rural and remote emergency nurse practitioner beyond the 'fast track' model of care HNE Handover: For Nurses and Midwives 7(1), 1-6

[16] PwC Consulting (2019) The cost of perinatal depression and anxiety in Australia https://www.pc.gov.au/__data/assets/pdf_file/0017/250811/sub752-mental-health-attachment.pdf p.14

19. The changing and varied healthcare needs of the Australia's diverse population has considerable impacts upon the job roles of members working in the care and support workforce. Along with an increasing life expectancy, rising rates of chronic disease, cancer, mental ill health, and disability care needs means that there are many more people with multiple and complex conditions that need individualised assessment, care, management, and treatment from a variety of different subsectors within the wider care and support sector.

20. One of the corollaries of an ageing population and longer life expectancy (particularly among groups that typically have a shorter than the average mainstream life expectancy, e.g. Aboriginal and Torres Strait Islander people, those with mental ill-health and/or disability, drug users, and the homeless) is higher rates of comorbidities and dual diagnoses.[17] While ageing is neither synonymous with disability nor disease, living longer increases the likelihood of developing chronic illnesses. At present, 80 percent of Australians aged 65 years and over have four or more chronic conditions.[18] Modern medicine, nutrition, and social and health advancements means that many people both live longer but are doing so along with multiple health issues, including behavioural and mental health concerns.[19] Furthermore, the rates of these issues and concerns are increasing.[20] This has resulted in a situation where care is being provided for people who are on more medications, with more potential interactions, and are more prone to rapid changes in condition than the general population. This risk is complicated further for people with dementia, mental ill health, cognitive or intellectual disability, and communication issues, as these changes are not always readily evident.

21. Chronic illness is particularly prevalent among people who have dementia. People with dementia have complex care needs because of having a degenerative disease that affects cognitive, emotional, and physical function. People with dementia have an average of two to eight concomitant health conditions,[21] and 90 percent of people with dementia have at least one comorbidity,[22] which is a higher incidence than age-matched people without dementia.[23] The prevalence of dementia is projected to increase by 90 percent by 2037, with a 2.75 fold increase (to almost 1.2 million people) by 2056.

22. For these reasons described above, skilled health practitioners including nurses and midwives are needed to assess clients' baseline conditions, changes over time, and to evaluate the effects of interventions. However, due to low staffing levels and poor skills mixes across much of the care and support sector, particularly aged care, there are issues with unregulated, less qualified, lower-skilled workers (i.e. PCWs) taking on roles that otherwise would be (and should be) undertaken by nurses or other healthcare professionals.

23. The most effective way of ensuring high quality and safe aged care is by imposing requirements on the providers of that care to have a minimum number of trained care staff supported by registered and enrolled nurses in a mix that takes account of the care needs of their patients/residents/clients (case mix).

[17] Note that veterans are over-represented in many of these categories, particularly mental ill health, physical disability, substance use, and homelessness.

[18] Australian Bureau of Statistics (2019)

[19] "In 2017-18, one in five (20.1%) or 4.8 million Australians had a mental or behavioural condition, an increase from 4.0 million Australians (17.5%) in 2014-15." Australian Bureau of Statistics (2019)]

[20] "Just under half (47.3%) of Australians had one or more chronic conditions in 2017-18, an increase from 2007-08 when two-fifths (42.2%) of people had one or more chronic conditions." Ibid.

[21] Wilkinson E (2013). Providing quality dementia care. Nursing and Residential Care, 14 (2): 93-5

[22] Browne J; Edwards DA; Rhodes KM; Brimicombe DJ; Payne RA (2017). Association of comorbidity and health service usage among patients with dementia in the UK: a population-based study. BMJ Open, 7 (3): 1-8

[23] Poblador-Plou, B; Calderon-Larranaga, A; Marta-Moreno, J; Hancco-Saavedra, J; Sicras-Mainar, A; Soljak, M; Prados-Torres A (2014). Comorbidity of dementia: a cross-sectional study of primary care older patients. BioMed Central Psychiatry, 14 (l): 84-92

Mental Health

24. Many people do not receive the mental health care they require due to limited service availability, funding gaps, lack of cultural safety, convoluted referral pathways, and fragmented care.[24] Better use of already qualified nurses, mental health nurses, and midwives is an easy and cost-effective strategy to increase the efficacy of Australia's mental health workforce and recognises that not all mental healthcare occurs in specifically mental health services. In our submission to the Productivity Commission Report on Mental Health,[25] the ANMF called for the reinstatement of nurse-led programs such as the Mental Health Nurse Incentive Program (MHNIP), which allowed mental health nurses to provide cost effective community-based mental health care. This program is especially important in areas with poor access to general practice and specialist mental health professionals and services.

25. Mental health nurses perform invaluable work both with people who have emerging mental ill health and those who have experienced prolonged or recurring mental ill health. Nurses working in mental health add clinical experience to their generalist foundation, with many nurses in the speciality having or working towards a postgraduate mental health qualification. The expertise of mental health nurses cannot be underestimated, in both the direct provision of care and through education of consumers, families, colleagues across sectors and specialties, and the wider community. Mental health nurses must be considered to be a central and ongoing feature of Australia's health and support sectors and their value both now and in the future effectively leveraged to provide important contributions to the care of the Australian community.

26. Despite there being over Australian 24,000 nurses who identify their primary area of practice as mental health,[26] this is not enough to meet present and projected future demand. As the Productivity Commission's Draft Report noted; mental health nurses are a critical part of the current mental health workforce, being the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental and physical health and care coordination. The ANMF agrees that the number of mental health nurses practicing in Australia — in general practice clinics, community health services, and aged care facilities — should be significantly increased.[27] The dearth of mental health nurses is a situation that is shared across the developed world. The causes are multifactorial, including unsatisfactory workplace conditions, concerns about violence, and stigma towards mental ill health and mental health work. These issues must be comprehensively addressed if the sector is to attract new nurses and retain those already working in the specialty.

Over the past 5 years how have you seen the care and support workforce change?

27. Over the past five years and beyond, the composition of the direct care nursing workforce has changed, most noticeably in aged care, resulting in a loss of skill in the workforce and dilution of the capacity of RNs and ENs in the workforce. This has occurred against a setting of increased age, co-morbidity, and complex health conditions of people entering residential care and similar, broader patters of health issues in the wider community including veteran health and mental health. The need for more RNs and ENs in each of these sectors will only increase as the population ages.

[24] Australian Government Productivity Commission (2020) Mental Health Inquiry report https://www.pc.gov.au/inquiries/completed/mental-health/report

[25] ANMF (2019) Submission to the Productivity Commission: The Social and Economic Benefits of Improving Mental Health https://anmf.org.au/documents/submissions/ANMF_Submission_to_Productivity_Commission_The_Social_and_Economic_Benefits_of_Improving_Mental_Health_5April2019.pdf

[26] Department of Health workforce data NHWDS - Nursing and Midwifery Factsheets 2019 https://hwd.health.gov.au/publications. html

[27] Mental Health Productivity Commission Draft Report Overview and recommendations (2019) https://www.pc.gov.au/inquiries/ current/mental-health/draft/mental-health-draft-overview.pdf

The ANMF highlights that the overall reduction in nursing numbers and subsequent skills dilution has had, and continues to have, direct implications for the quality and safety of care delivered.

28. Across these sectors, high workloads, unreasonable nurse to patient/client ratios, stress, and occupational violence are commonplace. Wages in the care and support sector are low when compared to health care (i.e. public sector nursing wages) and many care workers are paid at award rates or only marginally above. These factors contribute to low morale, burn out, decisions to leave the sector and create barriers to recruitment to the sector. Further, they obviously impact on the quality and safety of care provided.

29. Another issue observed over recent years is the increasing casualisation of the workforce across the sector. Problems faced by casual workers include; lack of guaranteed hours of work, irregular hours, no paid personal or annual leave, termination of employment without notice - unless notice is required by a registered agreement, award or employment contract. Casual employment has financial, psychological, social and industrial implications, such as:

    a) casual loadings not fully compensating for loss of conditions such as paid annual leave and personal leave

    b) loss of career opportunities;

    c) lack of job security;

    d) reduced access to continuing education provided in the workplace;

    e) limited ability to secure finance due to uncertain earnings;

    f) inability to properly plan individual caring, family and community activities; and

    g) a negative effect on retirement benefits for example, superannuation.

    A further issue with casual work is the impact that taking sick leave or turning down shifts can have due to fear of losing further work, reduced shifts, or losing a job completely. This leads to workers still coming to work despite being unwell which has significant risks for clients/patients and other staff.

30. It is the position of the ANMF that the use of casual employees must not undermine:[28]

    a. the continuity of quality care;

    b. the knowledge and skill base of employees providing care to patients/clients/residents;

    c. the time available for patient/client/resident care by permanent staff orientating or assisting casual employees;

    d. the employer's duty to provide an environment in which employees can deliver safe care; or

    e. permanent employment opportunities.

31. The ANMF suggests that the number of employees employed on a casual basis must be limited to the level required to meet temporary or exceptional circumstances which cannot be met by the level of permanent staff. For example, casual employees can be engaged for such things as covering short-term leave, one on one care ('specialling') of a patient/client/resident or in circumstances of exceptional demand on health or aged care services.

[28] Australian Nursing and Midwifery Federation. (2021). ANMF Position Statement: Casual employment in nursing, midwifery and care work. May 2019. Available: https://anmf.org.au/documents/policies/PS_Casual_Employment_Nursing_Midwifery_and_Care_Work.pdf

When engaging casual employees, employers should preference established 'banks' or 'pools' of experienced nurses, midwives, and PCWs before sourcing staff from external employment agencies. Employers should ensure casual employees engaged through employment agencies are provided with appropriate insurance, training and vetting for suitability of employment. Employers should source casual employees from reputable employment agencies that do not deduct or charge unreasonable placement fees on casual employees.

How do you expect the workforce to change in the near-term and out to 2050?

32. There is extensive and compelling evidence demonstrating that Australia and many other countries around the world, particularly low to middle income countries, are expected to face intensifying workforce shortages within the care and support sector. There are many reasons for this including ageing populations with higher life expectancies. The ageing population is expected to impact on the workforce in two main ways; by increasing the number of people who need to access care and support services and through the increasing age of many members of the workforce itself who are likely to remain in the workforce for longer. Here, the ANMF advises that it will be necessary to effectively support both older workers to remain in the workforce, if they wish to, as they have important skills and experience to offer and to ensure younger workers are recruited and retained as older workers leave.

33. Australia's care and support sector has been reliant on the recruitment of international nurses, midwives, and PCWs often from low to middle income countries and the sector employs a large and increasing proportion of overseas-born staff. This is anticipated to continue in the aged care sector with the Royal Commission into Aged Care Safety and Quality including a consideration of immigration within Recommendation 75 regarding aged care workforce planning which has been accepted by the Government.[29] It is also anticipated that reliance on overseas-born workers will also continue in mental health, disability care, veteran health, and rural regional and remote health.

34. Recruitment of nurses and midwives from less resourced countries to meet the healthcare needs of well-resourced nations was of such growing concern the World Health Organization declared that active recruitment of healthcare workers and its related migration as one of the greatest global health threats in the 21st century.[30] As such, the ANMF views any workforce planning, including for the recruitment of international PCWs, to be an important issue for future workforce planning in Australia. The ANMF advances the following recommendations regarding recruitment of overseas workers:[31]

    - Overseas recruitment should not be the primary strategy to overcome workforce shortages in Australia or as an alternative to education and recruitment opportunities for the existing domestic workforce.
    - Overseas working visa programs should not be utilised by Australian Governments as a solution to the underemployment or unemployment of domestic graduates.
    - Governments must commit additional resources towards workforce planning, education, remuneration, and conditions to attract and retain domestic workers to the sector.
    - Employers should exhaust all avenues to employ members of the domestic workforce and introduce a range of strategies aimed at attracting and retaining domestic workers.
    - Internationally recruited workers must be provided with the same employment conditions as those offered to domestic workers.

[29] Australian Government Department of Health. (2021) Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety May 2021. Australian Government Department of Health. Available: https://www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

[30] Shaffer, FA. et al. (2016). Code of ethical international recruitment practices: the CGFNS alliance case study. Human Resources for Health. 14(31): 113-9. Available: https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-016-0127- 6#citeas

[31] Australian Nursing and Midwifery Federation. (2021). ANMF Policy: International recruitment of nurses and midwives – May 2021. Available: https://anmf.org.au/documents/policies/P_International_recruitment.pdf 36.By enhancing staffing and skills mix across the sector, the poor track record of the sector regarding the

What do you consider to be the key drivers of change to the care and support workforce into the future?

35. Addressing workforce shortages both in terms of the number of educationally prepared care staff i.e. those who have attained the minimum education requirement of a Certificate III in Individual Support employed across the sector, and via ensuring mandated minimum staffing levels and skills mix will greatly improve the care provided to people who access care and support services and will underpin better outcomes and greater wellbeing for staff, clients and providers, through the provision of respectful and dignified care.

36. By enhancing staffing and skills mix across the sector, the poor track record of the sector regarding the attraction and retention of staff – particularly nursing staff, could be addressed. Mandating minimum staffing levels and skills mix also addresses issues regarding; the sector's interfaces with the wider health and social services sectors and handover to other health professionals, the provision of individualised person-centred care, better engagement with family members and loved ones, improved capacity of services to offer better quality clinical placement positions for students, and ensuring better occupational health and safety and workplace conditions for staff members who are less likely to be overwhelmed by unfeasible workloads.

How will the workforce need to adapt?

37. It is important to not only consider how the workforce needs to adapt to the future requirements of healthcare in Australia but how the healthcare systems must change and adapt to the needs of people receiving care. The workforce is often the glue that holds health systems together and the workforce can only adapt to the extent to which a system enables it. Therefore, it is essential that this review balances the expectations of the care workforce with the healthcare systems required adaption.

38. The workforce across the sector will need to be much larger and comprise a greater skills mix of staff. Due to a projected increase in the number of people accessing services through the care and support sector, nursing, midwifery, and PCW education programs should prepare all workers to assist with care rehabilitation and the maintenance of optimal health for their patients/clients including older people, people living with disability, and people with mental ill health. These education programs should also provide nurses, midwives and PCWs with a greater understanding of the problems faced by people with diverse and complex needs and those of their families or primary carer/s.

39. To support and ensure the provision of safe, effective care PCWs must be regulated through registration under the Health Practitioner Regulation.[32]

Workforce Attraction, Retention and Development

To what extent are mobility and skills transferability between and across job roles important factors in workforce/worker attraction and retention?

40. Mobility and skills transferability between and across job roles are highly important factors for attraction and retention of staff in the care and support sector. Supported career progression, professional development, and opportunities to gain new skills and qualifications, are key factors for attracting and retaining staff. The ANMF recognises that the care and support workforce is not homogenous. The skills and training needed for a PCW in aged care will not be the same as those required for disability or community mental health, for instance. There is a baseline of skill, reflected in the Cert III in Individual Support, but the specialised nature of particular areas of care should also be recognised. Supporting career pathways is important for retention, however, this should not involve moving into work and responsibility that is outside the scope of the role or practice area.

32 Australian Nursing and Midwifery Federation. (2021). ANMF Position Statement: Registration of assistants in nursing – February 2021. Available: https://anmf.org.au/documents/policies/PS_registration_of_assistants_in_nursing.pdf

What strategies and tactics are most effective in attracting and retaining a workforce/worker with the right skills?

41. To attract and retain a suitably sized and skilled workforce and to enhance the care and support sector workforce's capacity and capability to provide high quality care a range of strategies and tactics must be considered. Improving working conditions must be part of any strategy to attract and retain care and support staff.

    a. Wages must be set at rates comparable to equivalent public sector rates. Minimum hourly rates must be sufficient to allow care workers to earn a decent living income.

    b. Ongoing permanent work must be preferenced over casual employment and contract or 'gig' work such as offered through labour hire platforms.

    c. Permanent work must be offered on the basis of the regular work performed, rather than on low or zero hour contract basis. Insecure work in the care sector is a disincentive to attracting and retaining staff.

    d. Workplaces must be proactive in ensuring the safety and wellbeing of workers and work health and safety reforms proposed in the Boland review[33] must be implemented as a priority across the sector. Issues of occupational violence, excessive workload and psychological harm create a negative perception of care work and impact retention in the sector.

    e. As discussed above, adequate staffing levels and skills mix are required to ensure safe and quality care can be delivered. This means, amongst other things, ensuring workers have time to deliver person centred care and complete administrative tasks in paid work time.

    f. Offering attractive working conditions, such as access to flexible family and carer friendly work arrangements, adequate leave entitlements, reasonable workloads are all necessary for attracting and retaining workers with the right skills.

42. All of the above strategies serve to promote the perception of care and support work as a valuable and valued sector in which to work. Working in the care and support sector must be maintained and promoted through policy and funding as an essential, valued part of the broader context of health and social services. At a broader community level it is important that positive cultural perceptions about people who access care and support services are promoted.

43. Ensuring effective attraction and retention of workers across the sector must also focus on attracting and supporting Aboriginal and Torres Strait Islander nurses, midwives, and PCWs which is also a major priority of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). This need is particularly acute in remote areas, where reduced access to health care is caused by the same factors that inhibit the employment of health care providers – distance, expense, and isolation. Representation of Aboriginal and Torres Strait Islander staff, along with supportive structures that make it easier for disadvantaged, rural, and remote candidates to undertake nursing qualifications (including clinical placements) will assist in making nursing, midwifery, and carer work a more attractive and achievable option for potential candidates.

44. To attract and retain a suitably skilled workforce it is necessary to understand the legal accountabilities and responsibilities of the existing workforce. Nurses and midwives are required to obtain and maintain registration by meeting professional standards and working within their scope of practice. The lack of available workforce and skill levels acts as a barrier to meeting those professional standards and the ability to work within the expected scope of practice. This tension acts as a deterrent to working in some areas of the care workforce and impacts the quality of care delivered.

[33] Review of the model WHS laws: Final report (safeworkaustralia.gov.au) Productivity Commission 2011, Caring for Older Australians: Overview, Report No.53, Final Inquiry Report, Canbera

45. Below, we have focussed on some selected key factors that are particularly important for the aged care sector more specifically:

Wage outcomes in the aged care sector

46. Wage outcomes for workers in the aged care sector must be improved to match equivalent public sector wages. Care work in the aged care sector has been recognised as undervalued in multiple reviews, including *Caring for Older Australians*[34] in 2011, *A Matter of Care*[35] in 2017 and the Aged Care Royal Commission Final Report: Care, Dignity and Respect.[36] The Royal Commission recommended health sector unions, including the ANMF, make application to the Fair Work Commission to increase minimum award wages on the basis that the current rates do not recognise the value of the work performed and/or are undervalued on the basis of gender.

47. The ANMF and HSU have issued Work Value applications at the Fair Work Commission in line with the Royal Commission recommendations for workers in the aged care sector, in both residential and home aged care. The applications seek an award rate increase of 25%, which if successful will bring award rates much closer to or in some instances to match public sector rates.

48. The Commonwealth Government must be an active participant in the FWC applications to improve award wages and agree to fund increases achieved by the applications. If award rates are improved this will have the effect of raising minimum rates under enterprise agreements. Commitment from Government to fund wage increases will give confidence to providers with respect to offering better wages through enterprise bargaining.

49. Reducing the discrepancy between wages in the public and private sector is an important strategy to attract and retain staff to non-public sector care work. While staff continue to earn less in the private sector than their counterparts in the public sector, they will continue to leave private sector care work. This is of particular relevance for the provision of residential aged care as the majority of these services are supplied by private providers.

50. Increasing award wages will make the aged care sector more attractive and assist in improving the perception of caring work as valuable work.

Transparency and accountability

51. Closely linked to increasing wages and improving career pathways in the aged care sector is the need to demonstrate transparency and accountability about how funding to the aged care sector is spent.

52. Both Government and employers must be required to demonstrate accountability and transparency with regard to funding allocated to wages. Government must be required to both disclose the amount of funding provided and be transparent about how and where funding is allocated. It should be clear as to how much funding goes to direct care. Employers must be required to demonstrate acquittal of funding allocated to direct care. Accountability and transparency about funding for direct care will promote confidence in the sector and assurance that funding is appropriately spent.

53. Sector funding must be linked to quality of care outcomes and determined through an evidence-based methodology to ensure that care standards are met. A measure of accountability is linking funding to meeting quality of care outcomes, including by reporting data about staffing levels and skills mix.

[34] A Matter of Care Australian's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018
[35] A Matter of Care Australian's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018
[36] Royal Commission into Aged Care Quality and Safety, Final Report (n 3)

Governance of the care and support sector must be robust and ensure best practice standards. Well governed organisations will attract and retain a competent and caring workforce and earn community confidence in the care and support sector.

What barriers exist to entry and establishing career pathways for the care and support workforce/ workers?

Registered Nurses

54. Nursing is a multifaceted, demanding and rewarding profession that relies upon the possession of a comprehensive knowledge base and the ability to apply that knowledge and clinical skills in the health care setting. In doing so, nurses are required to master an array of often complex clinical activities and procedures, exercise decision making and critical thinking, demonstrate clear communication and interpersonal skills, and continuously assess, implement, evaluate, and re-prioritise care to meet the often rapidly changing health conditions of the people for whom they are caring. Nurses do so with an understanding of the legal, ethical, and professional framework which governs their practice. Nurses are in the best position to initiate actions that minimise adverse events and negative outcomes forpatients.[37] We encourage the Commission to examine our submission to the recent Independent Review of Nursing Education in Australia which covers pertinent issues for both registered and enrolled nurses.[38]

55. Some of the barriers the ANMF sees that exist to the entry of the profession include:

- Attrition: While nursing is an attractive option for many people with degree programs close to being fully subscribed, not all candidates complete their qualification, not all graduates register with NMBA, and the days of nursing as a lifetime career are waning.[39] Further data analytics need to be collected to identify annual attrition numbers, types of education providers, and why student nurses are leaving their education program.

- Workforce numbers: The current rate of graduates registering is generally meeting graduate vacancies in both the public and private health settings.[40] However, we are less than a decade away from a consistently predicted national and international nursing shortage.[41] Attention must be directed to the retention of older nurses who are also the most skilled and experienced clinicians. As this experienced cohort transitions out of the workforce, opportunities for career development and post-graduate training are required to ensure sufficient numbers to meet demand across all areas of practice. Further work needs to be completed to ensure future workforce planning continues to ensure the required numbers of registered nurses and midwives are graduating and are supported in the development of their careers, while also retaining experienced registered nurses in the current workforce. There is not one responsible organisation or position which is required to collect, analyse and monitor nursing workforce numbers and future requirements, this must change. It is essential that data is timely, accurate and effectively analysed to enable inform future workforce policy.

- Clinical placements: When done well, clinical placements effectively prepare students as beginning level practitioners, for the workplace. Unfortunately, the ANMF's student and nurse members tell us regularly about inadequate clinical placement experiences.

[37] Aiken, LH; Clarke, SP; Cheung, RB; Sloane, DM; Silber, JH (2003). Educational levels of hospital nurses and surgical patient mortality. Journal of the American Medical Association, 290 (12): 1617-20
[38] ANMF. (2019) Submission to Educating the Nurse of the Future—Report of the Independent Review into Nursing Education [Online]. ANMF. Available: https://anmf.org.au/documents/submissions/ANMF_Submission_Nursing_education_review_4July19.pdf
[39] A ustralian Nursing and Midwifery Federation (2019). ANMF graduate data set: nurses and midwives. Melbourne: ANMF.
[40] Australian Nursing and Midwifery Federation (2019). ANMF graduate data set: nurses and midwives. Melbourne: ANMF.
[41] Commonwealth of Australia (2015). 2015 Intergenerational report: Australia in 2055. Online at https://treasury.gov.au/sites/default/ files/2019-03/2015_IGR.pdf

Achieving quality clinical placement experiences can be difficult; the ANMF acknowledges that the space education providers must compete in to negotiate quality clinical placements is onerous, complex, and influenced by several factors.[42] These include:

- Competition for places due to increasing student numbers, both in nursing and from other health disciplines, alongside post-graduate nursing students.
- Gaps in partnership arrangements between education providers and health care settings providing placement opportunities, resulting in a lack of transparency and oversight and, on occasion, little opportunity for education providers to influence how the clinical placement is experienced by students.
- The impost of students, via providers, of unregulated and variable placement costs. The ANMF has been told by education providers that they can be charged from $55 to over $120 per student per day. We note that this is a trend that has emerged over the last decade and is only applied to nursing students rather than all health professional undergraduates. This may have come about due to what the literature terms a 'Dedicated Education Model' where health services offering placements employ a clinical support person for student nursing placements.[43] The fees then reflect the health facility's costs, meaning the education provider pays the health service to deliver clinical support for their students on clinical placements. ANMF members have identified that model can result in less access to nurse educators and the primary even sole responsibility for the student falls to clinicians on the floor, who have varying communication, clinical, and teaching skills, and who have to teach and support students while managing an unmodified patient work load.[44]
- Educators report difficulties in challenging or influencing the way clinical placements are delivered. The limited numbers of placements compared to large numbers of students means health services have the 'upper hand', which allows them to dictate their expectations. While many health services are providing quality clinical placements, a tendency to prioritise service needs over education needs, has been reported to the ANMF. While clinical services are obviously a priority, there also needs to be a strong focus on supporting the workforce of the future to gain the necessary skills to contribute to an effective and efficient sector.
- Supervision and support by experienced registered nurses are critical for a successful experience for nursing students while on clinical placements. However, our members have expressed concern that at times there is no facilitator available to students. It is also essential that clinical facilitators/preceptors or buddies are experienced registered nurses who promote a positive learning culture, understand the importance of reflective practice and are able to provide appropriate constructive feedback from a profession specific perspective. It is vital that these senior members of staff are recognised and rewarded for the time and work they contribute to training and supervising the workforce of the future.

[42] Henderson A; Heel A; Twentyman M (2007). Enabling student placement through strategic partnerships between a health-care organization and tertiary institutions. Journal of Nursing Management 15 (1): 91-6, and, Peters K; Halcomb EJ; McInnes S (2013). Clinical placements in general practice: relationships between practice nurses and tertiary institutions. Nurse Education in Practice 13(3):186-91.

[43] Ford K; Courtney-Pratt H; Marlow A; Cooper J; Williams J; Mason R (2016). Quality clinical placements: the perspectives of undergraduate nursing students and their supervising nurses. Nurse Education Today. 37: 97-102.

[44] Miller, E; Cooper, M (2016). A registered nurse in 20 weeks? Australian Nursing and Midwifery Journal, 24(1):34+

Enrolled nurses

56. An enrolled nurse is a person who has completed the educational preparation that meets the NMBA requirement for registration. The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse. Enrolled nurses are responsible and accountable for their own practice. The registered nurse is accountable for the delegation of care to the enrolled nurse and to nsure he or she monitors the outcome of that delegated care. Enrolled nurses are an integral and valued member of the nursing team.

57. Preparation for an enrolled nurse is a Diploma of Nursing that is delivered over a minimum of 18 months in the Australian Vocational Education and Training (VET) sector. The program is delivered to meet the Australian Qualification Framework Level 5 and is embedded in the health training package. The Diploma of Nursing qualification, is comprised of 20 core units and five elective units of competence.

58. The diploma provides a generalist approach, covering the application of theory and skills required for care delivery under supervision, across the health sector. The education for enrolled nurses is meeting the needs of the second level nurse. Many of the concerns discussed in the registered nurse section about clinical placement also apply to enrolled nursing students. The issue of access and quality of clinical placements can be exacerbated further for diploma of nursing students as education providers suggest that Bachelor of Nursing students are sometimes prioritised over the diploma of nursing placement positions. Therefore, it is not uncommon for diploma of nursing placements to be provided only after Bachelor of Nursing students have been given access to clinical placement time. As with universities, education providers delivering the diploma have shared with the ANMF feeling powerless, and having 'fear of retribution' in the form of reduced placement access if they complain. The service agreements between the health service for clinical placements and the education providers needs to be strengthened and to clearly state the responsibilities of the education provider and those of the health service, particularly in relation to assessment of the student nurses progress, to meet their undergraduate curriculum for each clinical placement. Moreover, service agreements should include the model of clinical support being provided, the ratio of students to clinical educator, the minimum qualifications of the clinical educator, and a clear process for conflict resolution and/or escalating concerns.

59. There are also challenges in the articulation between the Diploma of Nursing and the Bachelor of Nursing. These challenges are two-fold: the first is that bachelor programs are unique, therefore requiring each to be separately mapped to the consistent diploma and secondly, the programs are delivered in two different education sectors. These challenges are, however, not insurmountable. Further work needs to be done to enable a national consistent articulation processes for enrolled nurses wanting to enrol into a Bachelor of Nursing.

Personal Care Workers

60. The role of personal care worker includes but is not limited to, support workers, health care workers, doulas, assistants in nursing or personal care assistants. Personal care workers may have a care worker qualification or no formal qualification for their role.

61. The current barriers faced by care staff, such as PCWs, to enter the workforce and progress is related to a lack of viable funding instruments and support by their employers. Employers must support workers to be educationally prepared in order for them to be confident and competent in providing services to clients/residents and their families. Support for education should be ongoing, in the form of continuing professional development (CPD), and promote the acquisition of higher skills through further training pathways i.e. organisational and financial support to upskill to a higher qualification that is in the interest of both the employee and employer.

62. PCWs are often low paid and their work undervalued with regard to the level of skill required to perform this important care work. In addition, PCWs are engaged more frequently on casual or part-time employment, meaning it is difficult for PCWs to earn sufficient income to earn a decent wage from working exclusively for one employer. Improvement in wages and establishing secure ongoing work are vital to attracting and retaining a skilled and well trained PCW workforce.

What role do formal and informal training have in contributing to the supply and ongoing development of the care and support workforce?

63. The current nursing education system in Australia is world-class and produces globally employable nursing graduates.[45] It produces effective, highly skilled and knowledgeable clinicians who comprise the greatest proportion of health care practitioners, and work across all health care settings, in every geographical region. Current education delivery is a combination of substantial theory across multiple areas of clinical expertise with interpersonal learning opportunities. As with any education program regular reviews are required to ensure they continue to meet with the requirements of the profession and people it cares for. Currently, there are areas which need to be enhanced within the program such as palliative care, dementia, aged care, and digital health capabilities. The Australian Nursing and Midwifery Accreditation Council (ANMAC) are due to start a review the ANMAC Registered Nurse Accreditation Standards later this year which will be an opportunity to include these enhancements.

64. Formal training is vital in establishing a level of education which provides the worker with the skills and knowledge to perform their job role confidently, competently and at the standard expected by the sector and the community. Informal training, such as ongoing CPD, is paramount to ensuring workers are continually engaged in the education process to ensure their skills and knowledge are up to date and of best practice. Organisations who provide regular CPD opportunities will grow a workforce that embraces learning and the sharing of knowledge, minimum practice standards within their organisation and workers who will continue to provide quality care for their care recipients well into the future. This has been well exemplified by staff gaining further expertise and training for infection prevention and control throughout the pandemic.

65. Workers who are confident, competent, and supported by their employer are more likely to remain in the organisation and/or care sector than those who struggle to maintain and/or improve upon their skills and knowledge.

66. A longstanding concern of the ANMF is that each year, a significant number of new graduate nurses and midwives and early career nurses have difficulty finding employment or sufficient hours of nursing/midwifery employment, and as a result, become disillusioned with the profession and seek work in alternative occupations. Not only is it a personal blow after years of study and expectation that work will be available in their chosen profession, it is a significant barrier to increasing workforce capacity and represents a loss, in terms of the broader economic impact on the community in general. Graduate programs to support new graduates to enter their chosen area of practice within the sector should be funded and promoted. Links between training and education providers and industry need to be strengthened to provide pathways into the workforce. Once in the workforce, graduate programs should offer ongoing training to enhance skills and consolidate experience. Employers need to be funded to offer appropriate support to graduates, including time for mentoring and training. Below, we go into further detail regarding graduate attraction, retention, and supported transition to practice.

[45] Schwartz S. (2019) Educating the Nurse of the Future—Report of the Independent Review into Nursing Education [Online]. Commonwealth of Australia. Available: https://www.health.gov.au/resources/publications/educating-the-nurse-of-the-future

67. Graduate or Transition to Practice Programs (TPP) are one informal way health services across the country including aged care facilities to deliver programs that support the employment and development of newly registered nurses and enrolled nurses. The role of any TPP must be to establish a supportive, positive framework within which nursing/midwifery graduates can further develop their knowledge, skills, and competence to develop the confidence they need as they move from student to a safe, competent beginning practitioner. When a TPP is delivered well, it provides a supportive environment for graduates to thrive. In a positive learning environment graduate nurses are valued for achievements in completing the undergraduate program, their individual scope of practice and what they bring to the profession.

68. Currently, there are concerns that TPPs are not providing a quality support program for enough nursing and or midwifery graduates. Our concern is exacerbated further within the aged care sector due to the poor staffing and skills mix and lack of registered nurse presence on each shift, seven days a week. The Victorian Branch of the ANMF worked with the Victorian Government to develop the Nursing and Midwifery Transition to Practice Program Guidelines 2018.[46] These guidelines provide an evidence-based guide to support health services to deliver an effective transition program and outline that programs should have the following features:

    - Flexibility: health services should design and create programs tailored for their graduate, organisation and setting.
    - Strong nursing leadership: Strong, visible and accessible nursing leadership is critical in creating a positive learning environment, driving every element of high-quality transition to practice programs.
    - Effective mentoring and preceptorship: Appropriately qualified and resourced nurse educators, clinical support nurses and preceptors (however titled) should be available to assist graduates, including the provision of one-on-one support or tailored learning opportunities.
    - Peer support: Support for graduates from all members of the health care team is essential.
    - Positive learning environment: Key features of a positive learning environment include ensuring graduates feel valued, welcomed, and safe to report errors and ask questions. Understaffing and poor skill mix are not features of a positive learning environment. Excessive clinical workloads for both the graduate and preceptor prevent members of the team from spending quality time with graduates.
    - Effective communication and individualised support: providing regular feedback and reviews for graduates enables the opportunity to identify areas of practice that are being delivered well by the graduate and areas that need further development.

69. The ANMF contends that every early career nurse should be supported in the transition from undergraduate student to nurse. The ANMF has been working with stakeholders over many years monitoring the transition period for graduates. As employment of graduates is required to provide transition to practice support/programs, the ANMF understands the first essential priority for graduating nurses is quality employment and secondly, that they are provided with evidence-based appropriate support in the transition period.

    Is there anything specific, which has not been previously identified that is a blocker to attraction, retention and/or ongoing workforce development?

70. COVID-19 outbreaks in aged care homes and disability care settings have had a range of negative impacts on how caring work is perceived and may impact on recruitment and retention. Workers in these settings have been exposed to high-risk workplaces with respect to the risks of contracting COVID-19; this has caused concern for workers about protecting their own families and households from the risk of infection.

[46] Victoria. Department of Health and Human Services (2018). Nursing and midwifery transition to practice programs: guidelines 2018. Melbourne: State Government

71. The spread of COVID-19 in care settings has been linked to staff in residential care settings working across more than one worksite. This has attracted negative media, some of which has been directed at the care workers, again creating a negative perception of the workforce.

72. Due to COVID-19 restrictions, including the need to self-isolate while awaiting test results and the need to quarantine due to potential exposure means some care and support workers have lost income during the course of the pandemic. Further, workers can be required to use their own time to be vaccinated and either personal leave or unpaid time to recover from adverse reaction to vaccination.

73. While paid special leave is provided in some settings for isolation, quarantine and to a limited extent vaccination related circumstances, paid leave to compensate workers for COVID related work absence is not universally available. Casual employees may have experienced loss of income due to loss of shifts and other workers may have been required to exhaust existing leave entitlements. The potential for income disruption or being required to exhaust leave intended for annual leave, long service leave or personal leave is a potential factor in making the sector unattractive. Strategies to support the workforce that would address the above barriers should include:

    - Long term availability of paid pandemic leave for getting tested, self-isolation, quarantine or adverse vaccination reaction purposes, for casual and permanent workers in all care settings.
    - Promotion and support for all staff and vulnerable care recipients to receive the appropriate COVID-19 vaccine as soon as possible.
    - Broad measures to promote and support ongoing permanent work that makes working at one site a viable means to earning a decent living wage. A reduction in the reliance on the 'gig' economy to supply workforce is needed.
    - Strong messaging from all levels of Government that workers and their families will be supported to manage the impact of COVID-19 in workplaces. There needs to be a shift away from focussing on individuals and the spread of the virus.

System Settings

In addition to previously identified system complexities (for example, funding, pricing, regulation), are there any other system issues (big or small) that are impacting the care and support workforce and the capacity to deliver quality care and support?

74. The ANMF argues that lack of safe staffing levels and skills mix is one of the most important issues that impact on the capacity of the care and support workforce to deliver high-quality care and support. This is evident in the findings of many reports and inquiries both in Australia and overseas and applies to each of the sectors covered by the Commission's study. An increasing and undeniable body of evidence demonstrates clear relationships between nurse and midwife staffing levels and skills mix and the provision of safe, quality, and respectful care. There is strong evidence validating the positive impact that an appropriate and safe number of registered nurses and midwives will have on clinical outcomes. There are well-established causal links between safe staffing levels and skills mix and quality health outcomes for people and the work health and safety of nurses and midwives and assistants in nursing.

75. The ANMF argues that there must be in place a minimum staffing system that is enforceable and is supported by the nursing and midwifery professions. Excessive staff turnover, absenteeism and injury, which may occur with inadequate staffing levels and skills mix, especially in the absence of qualified health professionals, can adversely affect staff morale and contribute to financial inefficiencies. Lack of sufficient numbers of the right kinds of staff also impacts upon the ability of a sector to provide suitable

76. The ANMF's policy on safe staffing of services that employ nurses and midwives recommends that methodologies used to determine nursing and midwifery staffing levels and skills mix must enable the provision of nursing and midwifery care in accordance with the Professional Practice Framework of the Nursing and Midwifery Board of Australia (NMBA). Staffing methodologies must:[47]

    - Enable nurses and midwives to meet their legal and professional obligations.
    - Support nurses and midwives in their professional judgement.
    - Enable nurses and midwives to work within the professions' scope of practice and to their full individual scope of practice.
    - Take into account variability of needs, outcome, and safety and quality data of the people for whom nurses and midwives provide care.
    - Support ongoing professional development.

77. Nurses and midwives must have decision-making power in relation to the development, implementation and evaluation of systems designed to determine the staffing and skills mix of nursing and midwifery services. Nurses and midwives should also be involved in the establishment of any nursing and midwifery service delivery costs, to ensure accurate, reliable, transparent, valid and timely methodology design, data input and interpretation. The system of accounting for nursing and midwifery care costs, to either individuals or groups, should accurately reflect nursing and midwifery costs and should be separated from costs generated by other departments and services and nursing and midwifery involvement in work unrelated to nursing and midwifery care should be costed separately. Finally, staffing methodologies used to determine nursing and midwifery staffing levels and skills mix and data pertinent to budget planning, control and justification must be easily available to the nurses and midwives using those systems.

Thin Markets

What strategies, initiatives and organisational structures are effective in improving the availability and sustainability of the care and support workforce in thin markets?

78. The ANMF prefers to consider 'thin markets' in a way that better characterises them not in economic terms but rather as places where people live, work, and seek care and support closer to home. The characterisation of rural, regional, and remote areas in purely market-based terms appears to be dehumanising and risks shifting the focus from the provision of safe, effective, meaningful care to a diverse and currently under-served demographic to considerations of market forces and competition between providers. Indeed, competition including within 'thin markets' appears to be ineffective and largely unrelated to better care and outcomes from a recent aged care sector working paper.[48]

79. There is ample research evidence focussed upon interventions to improve attraction and retention of care and support workers in rural and under-severed areas including a recent systematic review of systematic reviews.[49] Unfortunately however, included studies found little evidence to demonstrate the effectiveness of the included interventions. Key findings showed that various regulatory measures were able to attract health workers to rural and underserved areas, especially when obligations were attached to incentives. Health workers were likely to relocate from these areas once their obligations were completed, however. This means that further attention must be focussed on ensuring rural, regional, and remote communities, health and support services are attractive and rewarding places to live and work.

[47] Australian Nursing and Midwifery Federation. (2021). ANMF Policy: Safe staffing of nursing and midwifery services – February 2021. Available: https://anmf.org.au/documents/policies/P_Safe_Staffing_of_Nursing_Midwifery_Services.pdf

[48] Yang O, Yong J, Zhang Y, Scott A. (2021) Competition, prices and quality of residential aged care in Australia. Melbourne Institute: Applied Economic & Social Research The University of Melbourne.

[49] Esu, EB, Chibuzor M, Aquaisua E, Udoh E et al. (2021) Interventions for improving attraction and retention of health workers in rural and underserved areas: a systematic review of systematic reviews, Journal of Public Health. 43(1):i54-66. Available: https://doi.org/10.1093/pubmed/fdaa235

Recruiting rural students and rural placements improved attraction and retention although most studies were without control groups, which made conclusions on effectiveness difficult. This highlights one of the ANMF's key areas of focus in advocating for further support for regional universities and vocational training; it must incentivise quality rather than allowing the sector to accept a less or standard. Overall, cost-effective utilization of limited resources and the adoption and implementation of evidence-based health workforce policies and interventions that are tailored to meet local health system contexts and needs are essential.

80. The ANMF has made numerous submissions focussing on key workforce issues relevant to rural, regional, and remote areas which should be examined by the Commission during its study. These have focussed on aged care,[50, 51] mental health.[52] We also highlight that as described above, there must be a priority focus on growing and supporting the Aboriginal and Torres Strait Islander workforce particularly in rural, regional, and remote areas.

Technology

What role do you see for technology in enabling the care and support workforce?

81. Digital health has the potential to, and is, improving efficiency of the health care system in general, and the effectiveness of an intervention, through a multitude of methods. While it is difficult to predict many of the innovations that lie ahead, it is essential that the nurses and care workers of the future, including those who are learning now, have the tools and skills to adapt to, and be involved with, the range of emerging and yet-to-be-imagined health technologies.

82. The rapid utilisation of technology in health care is, and will clearly continue to be, a significant contributor to enabling the care and support workforce. It is essential that the introduction of new technologies must be supported by evidence demonstrating improved consumer outcomes, enhancing care rather than detracting from its provision. Technology will change the ways people access services and how providers manage resources and staff, so identification and attention to technology adoption factors will be vital.

83. The ANMF highlights that the adoption of technological innovations must not come at the expense of the provision of meaningful human interactions and care provided by staff.

84. Other areas where technology will have a clear role in the health and support sector include; training and skills acquisition for the workforce including an agreed minimum standard of training for care workers, i.e. Certificate III in Individual Support for aged care, community care and disability support. Ongoing training (CPD) must be supported and/or provided for staff and staff should not be financially compromised to attend and given time during work hours to attend training. Technology may enable optimising the delivery of care and support provided that safe staffing and skills mix are upheld. Nurses must be confident in the delegation of certain care tasks to workers, knowing the level of skills and knowledge of the workers and that they can competently complete the tasks delegated. This will allow nurses to provide higher level clinical care.

[50] ANMF. (2019) Submission to the Royal Commission into Aged Care Quality and Safety - Aspects of Care in Residential, Home, and Flexible Aged Care Programs, Rural and Regional Issues for Service of Delivery of Aged Care, and Quality of Life for People Receiving Aged Care [Online]. ANMF. Available: https://anmf.org.au/documents/submissions/ANMF_Submission_to_RC_Quality_of_Life.pdf

[51] ANMF. (2019) Submission to the Royal Commission into Aged Care Quality and Safety - Aged Care in Regional and Remote Areas [Online]. ANMF. Available: Submission to the Royal Commission into Aged Care Quality and Safety - Aged Care in Regional and Remote Areas

[52] ANMF. (2018) Submission to the Senate Community Affairs References Committee Inquiry: Accessibility and quality of mental health services in rural and remote Australia [Online]. ANMF. Available: https://anmf.org.au/documents/submissions/ANMFSubmissionSenateInquiryAccessibilityandqualityofmentalhealthservicesinruralandremoteAustralia_May2018.pdf

Any future developments regarding technology must occur with appropriate levels of transparently allocated and utilised funding for training and further skills acquisition and ongoing monitoring evaluation to ensure standards are in place and being met through rigorous assessment of service providers.

Monitoring Framework

What should be included in a workforce monitoring framework?

85. Workforce monitoring frameworks should include benchmarks which reflect the diverse composition of the health workforce, the participation of community and Aboriginal and Torres Strait Islander health workers and others, and capture the multifaceted nature and complexities of developing a future-proofed workforce. Considerations must also include equity in accessibility, staffing and skills mix, remuneration, gender composition, and quality. Other key elements should also include improved data collection, linkage, feedback, and use to support the framework's application and evolution. Another important aspect of health workforce monitoring is gaining a clear and timely understanding of pressure points, risks, and the overall workforce climate of the care and support workforce.

Data Gaps

What workforce data gaps have you observed and how could these be addressed?

Lack of timely and sufficiently accurate data

86. The ANMF has long held concerns about both a lack of specific workforce data that distinguishes job groups and titles sufficiently and the time delay in provision of data. The lack of detailed up to date workforce data is an impediment to gauging an accurate picture of current workforce trends. As a membership organisation it is important to the ANMF to be able to represent the interests of members in a timely and accurate manner. For example, the Australian Government Department of Health commissions a national aged care census and survey (NACWCS). The latest report is the 2016 National aged care workforce census and survey – the aged care workforce – 2016. This is the fourth report produced with previous reports published in 2003, 2007 and 2012. While the data has limitations and is now out of date, it remains the only reliable source of information on size and characteristics of the aged care workforce.
87. The Aged Care Workforce data is also limited in that it does not collect data on the number of casual agency staff used in the provision of aged care.
88. The National Health Workforce Dataset (NHWDS) 2019 provides information on the average hours worked across nursing occupations, but to date does not provide break down on the type of employment. The data set will in future show employment type- full time, part-time and casual employment. This will be a welcome improvement to the dataset.
89. ABS data in relation to employment type is also limited. The means of identifying the number of casual employees is based on requesting data showing the number of employees without paid leave entitlements. This may not be a completely accurate way of identifying the true numbers of casual nursing and care workers.
90. ABS data provided under the ANZSCO classifications lacks specificity in job title description and contains overlap. For example, the ANZSCO classifications for "Nursing support and personal care workers" and "Aged and disabled carers" cover a broad range of different care workers including child care, aged care and disability care.

91. There is also overlap between the two groups, for example Nursing support and personal care workers provide assistance across a variety of health settings including community care which may include peoples' homes – similar to an "Aged and disabled carer" group.

Graduate and first-time registrant data concerns

92. Timely data on the number of nursing and midwifery graduates, the number of nursing and midwifery graduates registering to practice, and the number of graduates with and without employment is currently not available. This data is fundamental in understanding the size and nature of many workforce problems and a first step in facilitating employment opportunities for all nursing and midwifery graduates either in transition to practice programs or other meaningful employment.

93. Difficulty obtaining accurate and timely data about where and when nursing students move into employment after completion of studies is a significant obstacle in following these trends. One of our key areas of focus is the accuracy of data related to graduates, in terms of numbers graduating, numbers registering and numbers then seeking work in nursing and midwifery. There is currently no single organisation that has exclusive carriage of monitoring and publicly producing graduate nursing data. This information is essential to ensure a collective, nationally informed view of graduate employment and transition. Five key questions are required to be addressed by the data that is accurate, timely and released at least annually. These include:

    - Numbers of nursing and midwifery student commencements per year in a course leading to registration.
    - Numbers of nursing and midwifery course completions per year in a course leading to registration.
    - Numbers of new graduates registered (initial registration) from Australian Education providers in a one-year period (Australian Institute of Health and Welfare/ AIHW data regarding first time registrations).
    - Numbers of new graduates (from those initially registered) from Australian education providers, employed in nursing and midwifery.
    - Number of graduate transition to practice places.

94. Since the development of the framework the ANMF has worked closely with the Department of Education and Training, National Centre for Vocational Education Research and the Department of Health to analyse the data available using the agreed minimum data set as a framework. This data set was first developed in 2015 and has been updated every year since. The latest version of this data set is attached as a separate document.

95. The data set provides an informed picture of student commencements and completions for both the bachelor programs and diploma of nursing programs. It provides this national data over several years and then separates the data into states and territories. Initial registration with the NMBA for the two categories of nurse is also shown. However, there are many limitations in the available data. Statistics are currently not available on the number of students per year and as identified earlier in the submission, better data on attrition rates for programs is needed. We do not have a national understanding as to why students have chosen to leave or defer an undergraduate program. This is essential for making informed decisions on future requirements for a number of reasons including, ongoing development of ANMAC accreditation standards and monitoring plus planning for employment positions for newly graduating nurses. Further, the data does not enable a clear picture of employment of graduate nurses, therefore how many are employed, where they are employed and how long it took for them to gain employment.

96. The Australian Health Practitioner Regulation Agency (AHPRA) has the potential to provide insight on this data. AHPRA could link student registration data which is provided yearly by education providers to their registration number when the student has completed the program. If AHPRA's systems enabled student registration numbers to be linked to ongoing registration numbers the intelligence this would create would be invaluable. De-identified student data could be tracked from an individual's commencement in an undergraduate program and throughout their career. The data would be extremely useful not only in predicting graduate employment but also in wider workforce planning.

97. The ANMF has been working to address these issues through a working group of nursing and midwifery organisations including representatives from the Chief Nursing and Midwifery Division of the Health Department, State/Territory Chief Nursing and Midwifery officers, the Nursing and Midwifery Board of Australia, the Council of Deans of Nursing and Midwifery, nurse educators, and a number of professional nursing associations. One of the key objectives of the group is to monitor and recommend changes to the collection of workforce data, data mining, minimum data sets and their associated definitions. A framework for this data was developed and agreed by the stakeholder collaboration from the Early Career Nursing Midwifery Working Group.

NHWDS -First time registration data – nurses and midwives

98. In the absence of NHWDS employment data for newly graduated nurses and midwives, the ANMF relies on first time registration data (based on registration ID numbers) provided on request as a proxy indicator. The latest data available is 2019. This approach contains a number of shortcomings. While it can be assumed the majority of First time registrants are new graduates, the data includes other registrants such as nurses and midwives who are overseas trained and registering to practise in Australia.

99. Tables in the attached Appendix, for example, separates data for domestic and overseas trained nurses and midwives, however, the high number of "inadequately described" or "non-respondents" means it is difficult to assess or estimate numbers of domestically qualified new registrants who are also new graduates.

    The ANMF welcomes any proposal to ensure more regular collection and production of workforce data that provides sector specific information about the constitution of the workforce.

Other Information

Is there any other information about the care and support workforce that you would like to provide?

APPENDIX

OVERVIEW - KEY WORKFORCE DATA AND DEMOGRAPHICS

Nursing and Midwifery Board of Australia – Registration data

1. The Nursing and Midwifery Board of Australia (NMBA) provides quarterly data profiling the nursing and midwifery workforce. The latest data includes the period 1 January 2021 to March 2021[56] and is summarised below. In total there are 462,243 registrations including general, non-practising, provisional registration and 18,865 on the pandemic response sub-register:

    - Of the total 455,464 are registered to practice.
    - 6434 of the total are non-practising and.
    - 345 have Provisional registration.

Nursing and midwifery workforce data

2. Nursing and midwifery workforce data, including demographic and employment information, is available from the National Health Workforce Dataset (NHWDS) published by the Australian Government Department of Health. This data is collected via the annual registration process and workforce survey completed at the time of registration on a voluntary basis. The latest published information is data based on the 2019 registration and workforce survey.[57]

3. In 2019 there were a total of 404,896 nurses and midwives registered including 5,532 non-practising registrants. Of the 399,364 general and provisional registrants:

    - 373,309 were in the "workforce" which includes: 344,941 employed; 17,740 on extended leave; and 10,628 looking for work
    - 26,055 were not in the "workforce". This includes: 11,301 who were overseas; 11,697 not looking for work and 3,035 who were retired
    - Of the 344,941 employed nurses and midwives 56% worked hours in the public sector; 34% in the private sector and 3% in both. (About 6% did not respond)

5. Data is also provided by nurse division. For purposes of this submission the following data is provided for Registered and Enrolled nurses, registered and enrolled nurses who have duel registration across two or three divisions.

6. For registered nurses, there were a total of 331,415 registrants. 308,982 were in the workforce including 286,907 employed in nursing; 9 employed in midwifery only; 14,905 on extended leave and 7161 looking for work.

7. Of the 22,433 registered nurses not in the workforce, 10,953 were overseas; 8,866 were not looking for work and 2614 were retired.

8. Of the 3,240 not in the workforce, 178 were overseas; 2,638 were not looking for work and 424 were retired.

9. The data also provides information on the principal area of practice and work setting of employed nurses.

[56] Nursing and Midwifery Board of Australia – statistics https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx
[57] Australian Government Department of Health- National Health Workforce Dataset (NHWDS) 2019 https://hwd.health.gov.au/resources/index.html?topic=nrmw

Registered nurses

10. In relation to employed registered nurses, 24% were employed in the clinical practice area of medical and surgical nursing; 11% were in employed in aged care; 14% in critical care and emergency; 9% in operating theatres; 7% in mental health; 4% in general and medical practice nursing; 4% in community nursing and 3% in rehabilitation and disability.

11. Approximately 64% of employed registered nurses worked primarily in public and private hospitals with the next most common place of employment residential health care facilities at 10% followed by community health care services at 8%. Another 4% worked in GP practices and 4% in Outpatient services.

Enrolled nurses

12. Similar data for enrolled nurses shows that 33% were employed in the clinical practice area of aged care; 27% were employed in medical and surgical nursing; 8% in mental health; 6% in general and medical practice nursing; 6% in rehabilitation and disability and 4% in community nursing.

13. Almost half (47%) of employed enrolled nurses worked in public and private hospitals; 29% worked in Residential health care facilities and 5% in community health care services.

14. Further information detailing area of practice, work setting and other demographic data is available in the NHWDS Facts sheets attached.

Aged care workforce data – 2016 (NACWCS)

15. The Australian Government Department of Health commissions a national aged care census and survey (NACWCS). The following tables are drawn from the 2016 census and survey data, being the most recent data available. It provides an overview of the size and composition of the workforce in residential aged care and community care.

Residential aged care

Table 1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

Occupation	2003	2007	2012	2016
All PAYG employees	156,823	174,866	202,344	235,764
Direct care employees	115,660	133,314	147,086	153,854

Source: Census of residential aged care facilities (weighted estimates)

Table 2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)	386 (0.3)
Registered Nurse (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)	22,455 (14.6)
Enrolled Nurse (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)	15,697 (10.2)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)	108,126 (70.3)
Allied Health Professional (AHP)*	8,895* (7.4)	9,875* (7.4)	2,648 (1.8)	2,210 (1.4)
Allied Health Assistant (AHA)*			5,001 (3.4)	4,979 (3.2)
Total number of employees (head-count) (%)	115,660 (100)	133,314 (100)	147,086 (100)	153,854 (100)

Source: Census of residential aged care facilities (weighted estimates).
In 2003 and 2007 both of these categories were combined under 'Allied Health'.

Home care and home support

16. The 2016 NACWCS data estimates total employment in home care and home support is 130,263 workers of which 86,463 are in direct care roles. The Table below shows a headcount of direct care roles by occupation for the years 2007, 2012 and 2016.

Table 3: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201 (0.2)	53 (0.1)
Registered Nurse	7,555 (10.2)	7,631 (8.2)	6,969 (8.1)
Enrolled Nurse	2,000 (2.7)	3,641 (3.9)	1,888 (2.2)
Community Care Worker	60,587 (81.8)	76,046 (81.4)	72,495 (83.8)
Allied Health Professional*	3,925 (5.3)	3,921 (4.2)	4,062 (4.7)
Allied Health Assistant*		1,919 (2.1)	995 (1.2)
Total number of employees (headcount) (%)	74,067 (100)	93,359 (100)	86,463 (100)

Source: Census of home care and home support aged care outlets.
* Note: in 2007, these categories were combined under Allied Health.

Employment in residential and community aged care, the nursing workforce and Australian workforce

17. The table below compares characteristics of the employment between residential aged care and community care workforce, nursing workforce in general and the Australian workforce as a whole based on 2016 census data.

18. Overwhelmingly care work across all work settings is performed by women. A breakdown of RN, EN and carer occupations in the residential and community care workforce in 2016 shows that 87% of the residential direct care workforce were female[58], and 89% of employees working home and community care.[59] Similarly, 89% of the nursing and midwifery workforce are female.[60]

19. Across the three occupations, RN, EN, AIN/PCW/CCW, the community care workforce is slightly older than the residential care workforce. Nurses employed in both residential and community care are older than the average age of nurses in general. For RNs, the median age is 47 and 48 in residential and community care respectively compared to an average age of 43.9 for RNs generally. Similarly for ENs, median age is 50 and 51 in residential and community care, compared to an average of 46.1 for ENs overall. For the AIN/PCW/CCW group, the community care workforce is older than the residential care workforce – 52 compared with a median age of 46 in residential care.

20. Overwhelmingly, the residential and community care workforce is employed on a part time basis. A significant number of employees in both the residential and community care workforce, (30% and 40% respectively), indicated they want to work more hours suggesting a significant level of underemployment in the sector.

21. The percentage of part time employment for all nursing and care occupations is significantly above the rate of the Australian workforce overall. In residential care, 78.1% of the direct care workforce is employed part time compared to 32.7% in the general community. In community care, the figure is 75.3% compared to 32.7% in the Australian workforce.

[58] The Aged Care Workforce, op.cit., 15
[59] Ibid., 74
[60] Op.cit. (NHWDS) 2019 – https://hwd.health.gov.au/resources/publications/factsheet-nrmw-2019.html

22. Additionally, the percentage of employees with full time employment is extremely low in both the residential and community care sectors. Just 11.9% and 11.2% of the direct care workforce are employed full time in residential and community care respectively. Compared to 62% in the Australian workforce overall.

23. The percentage of direct care employees in both residential and community care engaged on a casual or contract basis is below the general workforce figure of 25%. 10.1% in residential and 13.5% in community care. However, limitations of the Aged Care Workforce survey means data is not collected on the number of casual agency staff used in the provision of aged care services.

24. The NHWDS provides information on the average hours worked across nursing occupations and will, in the future, provide data on the type of employment, (full time; part time and casual employment). The average hours of work for a registered nurse is 33.5 hours per week and 31.6 hours for an enrolled nurse.[61]

25. ABS data from the 2016 census indicates there were 221,000 Registered nurses counted and 46.4% recorded as part time and 45.7% full time. For 34,000 Enrolled nurses, 52.2% were part time and 39% full time.[62]

26. ABS data requested by the ANMF on the number of casual employees represented as those without paid leave entitlements for the November quarter 2020 indicates significant numbers of the nursing and care workforce are employed on a casual basis including 32,500 registered nurses; 4,100 enrolled nurses; 19,600 nursing support and personal care workers and 87,900 aged and disabled carers.[63]

Table 4: Gender -Age –Employment status comparison

	Residential aged care (1)			Community care (1)			Nursing Workforce (NHWDS) (2)			All Occuptions (4)
	RN	**EN**	**AIN/PCW**	**RN**	**EN**	**AIN/ CCW**	**RN**	**EN**	**AIN/ PCW/**	
CCW										
Female	87.6%	91.4%	86.2%	93.7%	94.3%	88.8%	88.3%	89.8%	Not included in NHWDS	47.5%
Male	12.6%	8.6%	13.8%	6.3%	5.7%	11.2%	11.7%	10.2%		52.5%
Age	47 median	50 median	46 median	48 median	51 median	52				
median	43.4 average	45.3 average		40-45						
median										
FT	22.4%	13.4%	8.9%	34.9%	23.8%	5.7%				62%
PT	67.7%	78.9%	80.3%	59.4%	71.5%	79%				32.7%
Casual	9.8%	7.8%	10.8%	5.7%	4.7%	15.3%	13% (3)	NA		25% (5)

Notes:

1. The Aged Care Workforce, 2016 Mavromaras K, Knight G, Isherwood L, et al. 2017
2. National Health Workforce Dataset (NHWDS) 2019 – https://hwd.health.gov.au/resources/publications/factsheet-nrmw-2019.html
3. ABS 2019, customised report. Labour Force, Australia, Quarterly May 2019 for employees by paid leave entitlement status by select occupations
4. Department of Jobs and Small Business – Occupational Profiles Summary – Australia. Based on ABS data – Census of Population and Housing 2016, Place of Usual Residence
5. ABS 6333.0 Characteristics of Employment, Australia. August 2016

[61] Ibid
[62] Department of Jobs and Small Business – Occupational Profiles Summary – Australia. Based on ABS data – Census of Population and Housing 2016, Place of Usual Residence

ABS customised labour force data

27. Outside the NACWCS aged care data, (limited to residential and community aged care), AIN/PCW workforce information is available from ABS labour force data. The following table is extracted from an ABS customised report providing quarterly data for relevant ANZSCO occupations including AINs/ PCWs however titled.

28. The ANZSCO classifications for "Nursing support and personal care workers" and "Aged and disabled carers" cover a broad range of different care workers including child care, aged care and disability care. There is also overlap between the two groups, for example Nursing support and personal care workers provide assistance across a variety of health settings including community care which may include peoples' homes – similar to an "Aged and disabled carer" group.

Table 5: Based on ABS customised report of 6291.0.55.003 - Labour Force, Australia, Detailed, Quarterly, August 19 - November 20 for employees by paid leave entitlements status by select occupations

Paid leave entitlements status	Occupation (ANZSCO)	Aug-19	Nov-19	Feb-20	May-20	Aug- 20	Nov -20
Total Employees	Midwifery and Nursing Professionals (254)	343,300	345,200	345,800	348,400	366,700	341,200
	Registered Nurses (2544)	297,900	295,900	296,000	297,600	299,000	295,000
	Enrolled and mothercraft nurses (4114)	25,200	19,200	23,200	20,400	21,700	34,600
	Nursing Support and Personal Care Workers (4233)	91,900	103,600	100,700	85,200	86,500	82,800
	Aged and Disabled Carers (4231)	190,000	204,100	214,600	202,900	223,400	219,600

Note:The data for 4114 Enrolled and Mothercraft Nurses and 2541 Midwives is volatile. Sampling error is measured by relative standard errors (RSEs). The RSEs for these occupations were above 25%. As a rule, RSE of 25% or greater are subject to high sampling error and should be used with caution.

Higher Education student data – Course commencement, completions and total enrolments up to 2019

29. The following tables provide the latest available information on the number of students commencing and completing a course for initial registration as a nurse from 2012 to 2019. The demand for under-graduate nursing courses remains strong. The table below shows there were over 36,000 applications for undergraduate nursing courses in 2019. Course commencements (Table 7) totalled 26,493 in 2019, a 30% increase over a 5 year period since 2014.

Table 6: Undergraduate applications, offers and acceptances 2010-2019

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Applications	24,185	24,230	24,603	24,999	27,537	30,886	34,706	35,871	36,517	36,057
Offers	17,579	17,796	18,859	19,750	21,001	24,130	26,788	26,247	26,694	26,120
Acceptances	13,285	13,284	14,494	14,759	16,387	19,105	21,190	20,547	20,773	20,360,

Source: Undergraduate Applications Offers and Acceptances Publications, Australian Government Department of Education and Training

Table 7: Number of commencements for initial registration as a nurse by citizenship, 2012-2019

	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL	17,862	18,989	20,266	22,049	23,645	24,362	26,645	26,493
Australian citizen	14,141	15,108	16,174	17,617	18,874	19,071	20,222	19,197
New Zealand citizen	164	200	196	214	266	275	271	284
Permanent resident	922	867	959	984	980	1,106	1,201	1,290
Temporary entry permit	2,357	2,576	2,717	3,023	3,343	3,770	4,758	5,543
Other overseas	115	93	93	76	74	7	0	13
Permanent humanitarian visa	163	145	127	135	108	133	193	166

Source: 2012-2019 Selected Higher Education Statistics, Australian Government Department of Education and Training

30. The number of course completions over the 5-year period 2014-2019 increased by 48% with 17,178 graduates in 2019. The increasing number of graduates is very positive for the continued growth of the nursing and midwifery workforce however the ANMF is concerned that many new graduates and early career nurses have difficulty finding employment despite many employers claiming recruitment difficulties across a number of health and aged care settings.

Table 8: Number of completions for initial registration as a nurse by citizenship, 2012-2019

	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL	10,635	11,084	11,640	12,041	13,443	14,010	15,270	17,178
Australian citizen	8,063	8,481	8,991	9,254	10,399	10,849	11,717	12,806
New Zealand citizen	67	77	93	105	121	119	177	152
Permanent resident	342	431	467	410	465	512	566	653
Temporary entry permit	2,048	1,967	1,922	2,141	2,324	2,399	2,741	3,485
Other overseas	71	68	87	81	78	62	17	7
Permanent humanitarian visa	44	60	80	50	56	69	52	75

Source: 2012-2019 Selected Higher Education Statistics, Australian Government Department of Education and Training.

31. Overall there were almost 75,000 students enrolled in a nursing course, a 40% increase over the 5 years to 2019.

Table 9: Number of enrolments for initial registration as a nurse by citizenship, 2012-2019

	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL	48,421	50,678	53,542	57,893	62,365	65,977	71,157	74,897
Australian citizen	38,893	41,119	43,742	47,370	50,963	53,393	56,311	57,367
New Zealand citizen	374	446	492	539	628	709	793	805
Permanent resident	1,925	1,964	2,041	2,160	2,217	2,414	2,763	3,015
Temporary entry permit	6,678	6,566	6,669	7,261	8,024	8,987	10,823	13,183
Other overseas	203	201	198	178	161	84	21	19
Permanent humanitarian visa	348	382	400	385	372	390	446	508

Source: 2012-2019 Selected Higher Education Statistics, Australian Government Department of Education and Training

Enrolled nurse student data

32. The National Centre for Vocational Education Research (NCVER) provides data on Total Vet Activity (TVA) program enrolments and completions for students undertaking study programs leading to registration as an enrolled nurse. Tables 10 and 11 below show in 2019 total enrolments were 25,470 in 2019 and 6,855 students completed the education program for enrolled nursing.

Table 10: Program enrolments

	2015	2016	2017	2018	2019
International	1,775	2,450	3,370	4,270	3,675
Domestic	23,170	24,875	24,515	21,895	21,790
Total	24,945	27,325	27,885	26,165	25,470

Table 11: Completions

	2015	2016	2017	2018	2019
International	640	635	785	990	1,320
Domestic	5,425	6,010	6,415	6,215	5,535
Total	6,065	6,645	7,200	7,205	6,855

Source: NCVER 2020, Australian vocational education and training statistics: Total VET students and courses, NCVER, Adelaide.

Notes: Data in these tables have been rounded to the nearest five (5) to protect student confidentiality.

Data is for nationally recognised training only.

NHWDS -First time registration data – nurses and midwives

33. In the absence of NHWDS employment data for newly graduated nurses and midwives, the ANMF relies on first time registration data (based on registration ID numbers) provided on request as a proxy indicator. The latest data available is 2019. The shortcomings of the data are noted in the response to the question in relation to data gaps. The data also includes new registrants who are returning to the workforce after a long period absence.

Table 12: First year of registration by country of first qualification all nurses and midwives

	Extract year					
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
	N	N	N	N	N	N
Initial qualification country in nursing or midwifery						
Australia	12,018	11,823	13,692	14,073	14,681	14,137
Other	3,115	1,775	2,516	3,254	3,414	3,842
Non Respondent/Inadequately described	3,476	4,427	4,361	4,485	6,728	7,125
All	18,609	18,025	20,569	21,812	24,823	25,104

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2019

34. The table below, showing only data for 2019, provides a picture of the employment outcomes for new registrants. The NHWDS caution the results for new registration are likely to be affected by the timing of graduation, conducting of the survey and recruitment action by significant employers. As a result there are likely to be variations across jurisdictions and years.

35. Taking into account the shortcomings noted above, the data indicates there were 2,767 new registrants looking for work in their profession. Of those, 1,354 were employed elsewhere and 1403 were not employed. Also concerning is that 817 new registrants were not looking for work in nursing or midwifery and of those 477 were employed elsewhere. The balance were not employed. In all, there are potentially 3,244 (2767 plus 477) new registrants who could be working as a nurse or midwife who are not.

Table 13: First year of registration –new registrants by employment status – all nurses and midwives

Extract year 2019			
			All
			N
In the nursing and midwifery workforce			21,863
Employed in nursing or midwifery		18,568	
On extended leave		528	
Looking for work in nursing or midwifery		2,767	
Employed elsewhere	1,364		
Not employed	1,403		
Not in the nursing or midwifery workforce			1,430
Overseas		578	
Not looking for work in nursing or midwifery		817	
Employed elsewhere	477		
Not employed	340		
Retired from regular work		35	
Total nurses and midwives			**23,293**

Source: Extracted from NHWDS Nursing and Midwifery Practitioners, 2013-2019