THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to The Productivity Commission

Childcare and Early Childhood Learning

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Introduction

The Queensland Nurses' Union (QNU) thanks the Productivity Commission for providing the opportunity to comment on future options for childcare and early childhood learning.

The purpose of our submission is to highlight the specific characteristics of the nursing and midwifery[1] workforce that dictate the need for affordable, quality, flexible childcare that is continuously available at the workplace or elsewhere over the 24-hour-a-day, 7-day-a-week cycle. Our submission provides data on the nursing workforce, the current dilemma facing new graduates, work and family issues for QNU members and their childcare needs.

The QNU is the principal health union in Queensland. Nurses are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU covers all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

The Nursing Labour Force

The nursing labour force is unique in many ways. According to the Australian Institute of Health and Welfare (AIHW) (2013) the Australian nursing workforce has the following features:

Size of nursing and midwifery workforce

- In 2012, the total number of nurses and midwives registered in Australia was 334,078, a 6.8% (312,828) increase since 2008.
- There were 35,632 midwives registered and 30,792 employed, almost all of whom were also registered nurses.

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing.

- Between 2008 and 2012, the number of nurses and midwives employed in nursing or midwifery increased by 7.5% from 269,909 to 290,144.
- Of these people employed in nursing and midwifery, 238,520 were registered nurses (including midwives) and 51,624 were enrolled nurses.
- Overall, the nursing and midwifery workforce increased by 0.5% between 2008 and 2012, from 1,117.8 to 1,123.6 full-time equivalent nurses and midwives per 100,000 population.
- Nursing and midwifery supply across remoteness areas ranged from 1,071.3 full-time equivalent nurses and midwives per 100,000 population in outer regional areas to 1,302.8 in very remote areas.

Demography

- Nursing and midwifery continued to be a female-dominated profession, with women comprising 89.8% of employed nurses and midwives in 2012 (slightly down from 90.5% in 2008).
- The average age of the nursing and midwifery workforce increased slightly between 2008 and 2012, from 44.1 to 44.6 years.
- The proportion of employed nurses and midwives aged 50 or older increased from 35.1% to 39.1% over this period.

Working arrangements

- The average weekly hours worked by employed nurses and midwives remained the same between 2008 and 2012, at 33.4 hours.
- Of all employed clinical nurses and midwives, almost two-thirds (62.6%) worked in hospitals.
- The principal area of nursing and midwifery with the largest number of workers in 2012 was aged care (41,300).
- There were almost twice as many registered nurses working in the public sector compared to the private sector.
- Nurses employed in the public sector worked more hours on average than those in the private sector.

Queensland nursing workforce Profile

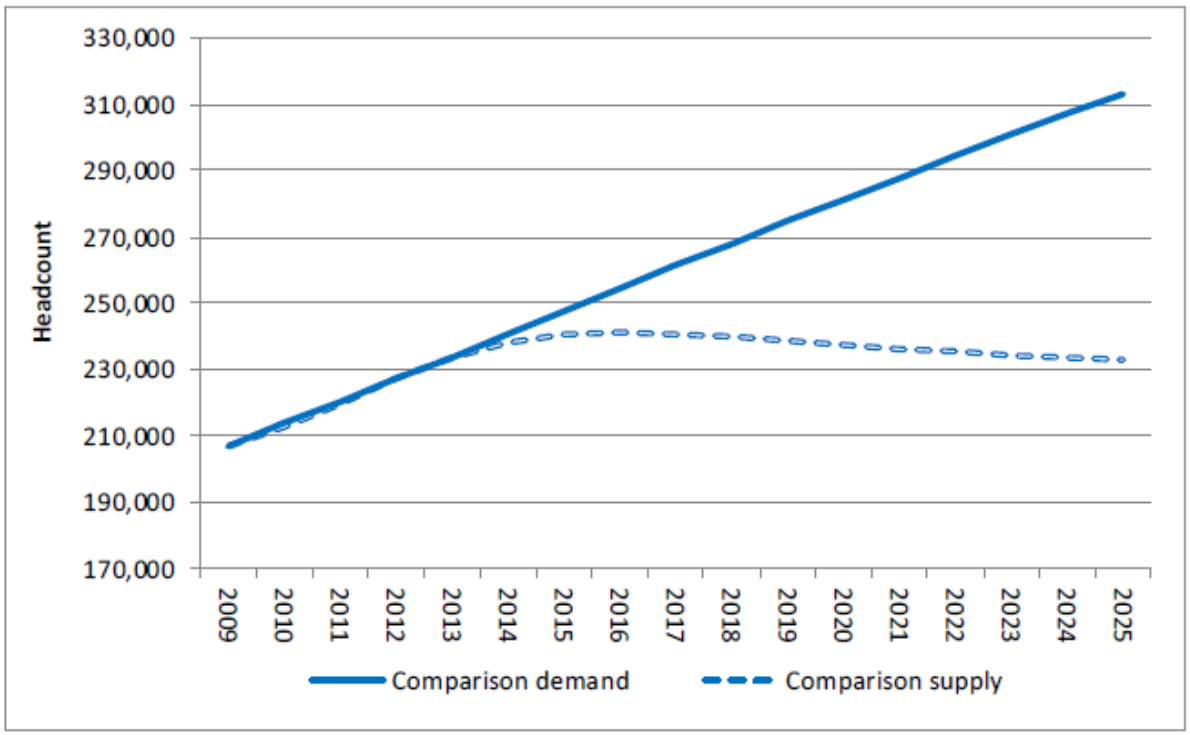
Nursing and midwifery is the largest workforce within the clinical streams.

- As at 30 June 2013, 66,795 nurses and midwives were employed in Queensland, with 49 per cent employed by Queensland Health (Nursing and Midwifery Board of Australia, 2013).
- Queensland Health employs approximately 77,000 staff, including 32,000 nurses (Queensland government, 2013a).
- The Queensland Health nursing workforce comprises 42 per cent of the entire workforce and 61 per cent of the clinical workforce (Queensland government, 2013a).
- Registered nurses in Queensland Health (Nurse Grade 5 and above) equate to 83 per cent (20,823 full-time equivalents) of the nursing workforce (Queensland government, 2013a).

Health Workforce Australia (HWA) is a Commonwealth statutory authority established by the Council of Australian Governments (COAG) to address the challenges of providing a skilled, flexible and innovative health workforce that meets the needs of the Australian community. HWA (2012) predicts that by 2025 there will be a *highly significant workforce shortage of around 109,000 nurses.* Without a nationally co-ordinated reform, Australia is likely to experience limitations in the delivery of high quality health services as a consequence of this shortfall (including a shortage of around 2,700 doctors). Other factors that will impact include:

- mal-distribution of the medical workforce resulting in less accessible services for Australians living in rural, remote and outer metropolitan regions;
- bottlenecks, inefficiency and insufficient capacity in the training system, especially for doctors; and
- continued reliance on poorly co-ordinated skilled migration to meet essential workforce requirements – with Australia having a high level of dependence on internationally recruited health professionals relative to most other OECD countries (Health Workforce Australia, 2012).

The following graph indicates the supply and demand projections for registered and enrolled nurses for 2009-2025.



Source: Health Workforce Australia (2012)

Employment of New Graduates

At the same time as HWA is predicting a looming nursing shortage, the QNU is extremely concerned about the impact that budget constraints are having on employment practices in Queensland Health (QH). In 2010, the (then) federal government announced $425 million over three years for clinical placements for students of professional health. Yet due to current state budget restrictions where QH has cut more than 1100 full time equivalent nursing positions, in 2013 only 28% of new graduates were unable to find permanent employment in QH at the end of their study (Queensland Health, 2013). QH's response has been to employ graduates on a temporary, part-time basis that offers no security for trainee nurses.

This situation is therefore shortsighted. It makes no sense firstly to identify an imminent workforce crisis and create more university places to meet demand, and then refuse to offer permanent employment to graduates. We need more nurses, not less. The current approach

seriously undermines the attractiveness of nursing and midwifery as a career and will make HWA's predictions even more dire.

The QNU believes that it is time to inject urgent funding into the health and aged care systems for nurse graduate employment programs to protect our nursing workforce and our health and aged care systems in the long term. Our new graduate nurses are a precious resource, an investment for the future that will achieve a healthier Australian community, not simply a threat to the budgetary bottom line.

Investing in Nursing

The case for investing in adequate numbers of nurses through effective recruitment and retention strategies such as extended hours child care becomes even more important in light of the following data around safe, quality patient care. International evidence confirms that where a registered nurse provides care, the healthcare system produces more positive outcomes and less adverse events.

The following snapshot of relevant literature indicates nursing's contribution to health outcomes.

Nurse staffing	• A decrease in nurse staffing is associated with increased health care costs of 40% (McCloskey et al., 2005) and inadequate nurse staffing is associated with adverse events which were estimated to cost AUD$4 billion in 2007 (based on data cited in Wilson et al., 1995). • Short staffed units have higher costs and patients have longer lengths of stay (McCue, Mark & Harless, 2003). • Increasing nurse staffing by one registered nurse hour per patient day may cost US$659 per case, but when compared with the cost per case of adverse events (US$2,384 per case), investing in nurse staffing can lead to a saving (Pappas, 2008). • It is estimated 26.7% of all infections could be avoided by appropriate nurse-to-patient ratios (Hugonnet, 2007).
Nursing workload	• Reducing nursing workloads by one patient per nurse (from five to four patients per nurse) is associated with one life saved per 1,000 admissions, at a cost of US$136,000 per life saved. Compared to the cost of other health care interventions, such as routine cervical screening (which costs $432,000 per life saved)

	implementing nurse to patient ratios of 1:4 is cost-effective (Rothberg, 2005).
Nursing skill-mix	• A clinically appropriate proportion of registered nurses on medical-surgical units has been associated with reduced medication errors and wound infections (McGillis et. al., 2004). • A multi-disciplinary team which includes registered nurses reduces in-patient mortality (Kane et. al., 2007; Needleman et. al., 2006; Dall et. al., 2009; Estabrooks et. al., 2005; Person et. al., 2004). • A clinically appropriate proportion of registered nurses in the mix of providers has been associated with shorter lengths of stay, lower rates of shock and cardiac arrest, urinary tract infections, pneumonia and respiratory failure (Department of Health and Ageing, 2009; Needleman et. al., 2002). • The presence of registered nurses in long-term care facilities has been associated with reduced adverse outcome, including pressure ulcers, hospital admissions, urinary tract infections, weight loss and deterioration in ability to perform activities of daily living (Horn et. al., 2005). • Registered nursing care is positively associated with reducing pneumonia, a complication which adds five days to a patient's average length of stay and is estimated to cost US$4,000 - $5,000 per additional day (Cho et al., 2003). Pneumonia is responsible for increasing length of stay by 75%, as well as a 220% increase in the probability of death, and an 84% increase in costs (Cho et al., 2003).
Work environment	• Poor work environments contribute substantially to nursing turnover which is estimated to cost AUD$150,000 per nurse (Chan et al., 2004).
Co-ordinating care	• When operating as part of a multi-disciplinary team, registered nurses assist in reducing waiting times and providing timely access to care by increasing the number of entry points to care, co-ordinating care and assisting patients in navigating the healthcare system (Canadian Nurses Association, 2012).

Source: Data cited in Armstrong (2009) and Queensland Health (2013b).

Work and Family Issues for QNU members

Since 2001, the QNU, in conjunction with researchers from the University of Queensland, Curtin University and Charles Sturt universities, have conducted a longitudinal study of Queensland nurses to identify factors impacting on nursing work (Eley, Hegney, Francis, 2011). As the QNU represents two thirds of Queensland's enrolled and registered nurses and approximately 50% of assistants in nursing/personal carers, the collected data provides the "Queensland nurses' voice".

The data from 2010, shown here replicates the trends of the 2001, 2004 and 2007studies. The study involved completion of a mailed questionnaire sent to 3750 QNU members stratified equally among the aged care, private and public sectors. In 2013, researchers continued the study and we are awaiting the results.

In 2010, the 74 question survey instrument was divided into sections addressing current employment and working conditions, responsibilities outside work, and professional development. In 2010, the response rate was 36.4% compared to 49.3%, 44.9% and 39.5% in 2001, 2004 and 2007, respectively.

Some significant issues of relevance to the prevalence of family responsibilities can be found in the survey data below. See Attachment 1 for qualitative responses regarding access to leave entitlements, shift work and child care availability.

Your Responsibilities Outside Work

Q. What significant family responsibilities do you have?

Half of the respondents indicated that they had significant family responsibilities. Nurses in the aged care sector were less likely to have any family responsibilities and also fewer dependent children. This is not unexpected given that aged care nurses have a higher average age of 50 years.

Family responsibilities

	Aged Care	Private	Public
None	265 56.0%	201 44.4%	179 44.5%
Dependent partner	60 12.7%	49 10.8%	42 10.4%
Dependent child	103 21.8%	170 37.5%	141 35.1%
Dependent grandchild	27 6.6%	18 4.0%	12 3.0%
Dependent disabled or ill	35 7.4%	37 8.2%	22 5.5%
Dependent parent	30 6.3%	27 6.0%	24 6.0%
Dependent other relative	8 1.7%	10 2.2%	10 2.5%
Other	12 2.5%	19 4.2%	25 6.2%

Available, Affordable, Quality Child Care

The availability of affordable, quality childcare services is a major determinant of workforce participation for all women. For many years, the QNU has been highlighting the particular need of nurses for affordable, quality extended-hours childcare. Given that 90 per cent of nurses are women and a majority of nurses are required to work shift work, this is a particularly important employment equity issue for the health industry and one that employers have not adequately considered to date.

It is the union's strong view that the lack of appropriate childcare services is a major barrier to nurses returning to the workforce after having children. (This is exacerbated by the high demand for care for under two year olds.) With the proliferation of non-standard working hours in other areas of employment this difficulty is beginning to become a "mainstream" problem for many working families.

In 2013, the (then) Australian government established a Child Care Flexibility Trial to enhance the capacity of the early childhood education sector and better meet the needs of Australian families. The (then) government allocated $5.5 million to care providers to trial flexible care models. Some of the initiatives the selected service providers are trialling include extended weekday care, overnight care and additional flexibility in catering for shift changes (Department of Education, 2013).

The QNU took part in these trials and worked with Family Day Care to provide extended hours of care for families in South East Queensland, Toowoomba and Townsville. The trial produced varying results with Townsville showing the greatest take-up. This was a new initiative involving a major shift away from traditional childcare outside standard hours. We urge the current federal government to continue with the trial and to support extended hours care for working parents across regions and sectors. The concept will take time to promote and implement, but it will ultimately provide nurses with more care options and therefore more opportunities to pursue their careers if they choose.

Although childcare is not an issue for all nurses at all times during their working lives, it does impact on nursing workforce planning for discrete groups of nurses. Specific skills-mix difficulties are created by the failure to address the childcare needs of this part of the nursing workforce.

As health services expect nurses and other health workers to provide a 24-hour-a-day, 7-day-a-week service, the QNU believes they have an obligation to assist their employees to balance their work and family responsibilities. However, despite our continued lobbying, QH has stated repeatedly that childcare is not their core business. The QNU strongly disagrees with this. Given that women make up the bulk of the nursing profession (and indeed QH's overall workforce), the balancing of work and family responsibilities is an inherent workforce planning and management issue for this agency.

For most people the availability of childcare is an integral part of balancing work and family responsibilities. For us, childcare is a core human resource management (HRM) issue. If it is not the responsibility of QH and other employers of nurses to ensure that appropriate child care services exist to enable their employees to work then we question where the responsibility does lie. In our experience the "market" has failed to provide such services for continuous shift workers. Government and employers must accept their responsibilities in this regard.

Currently in Queensland, private sector centres do not provide services that meet the needs of continuous shift workers. We acknowledge that many private and community sector services have extended their opening hours in recent years and this has enabled nurses who work early shifts only to utilise these services. We also note that in 2014 the Windsor School

Age Care Centre in Brisbane will be offering school age (5-12 years) care from 6.00am - 6.00pm on Saturdays and Sundays. This type of arrangement in other parts of the state would be of great benefit for nurses working weekend shifts.

We accept that even though facility based childcare services are our preferred option for child care services for nurses and other shift workers and the preferred option identified by the Senate Inquiry into Nursing (Senate Community Affairs References Committee, 2002), it is not always feasible for such services to be provided at all sites. However, we believe that it makes good policy sense to consider public hospitals as potential sites for extended hours childcare centres in those areas where there is a demand for after hours services. (For example, where there are employees requiring childcare who are employed in shift working personnel in services such as health, police and other emergency services and/or other shift working industries such as manufacturing, hospitality etc.) Public hospitals are usually centrally located and have security and emergency services on hand.

It has been our contention for some time that a needs analysis should be undertaken to ascertain level of demand for such services and that planning take place in a coordinated manner. If it can be demonstrated that existing services can meet the demand for such services (and this has largely not occurred to date) then these options should also be investigated. It may also be the case that the childcare "hubs" strategy can be utilised to meet a demand in particular areas.

The key issues are to identify the demand, barriers to delivering extended hours services and implement strategies to overcome these barriers through initiatives that are designed to meet the needs of the local community. No one solution will fit all circumstances - flexibility and innovation are required. More flexible childcare arrangements will benefit both employers and employees. For employers, advantages will arise from a reduction in training costs associated with absences, staff turnover and the loss of corporate knowledge. For nurses, this will mean greater flexibility and reliability in making their childcare arrangements and hence more scope to work outside the 'normal' hours that services are currently limited to.

Conclusion

In addition to the provision of affordable, quality childcare, we also see the need for strategies that address the industrial relations, health and safety, equity and social implications of long working and/or unsociable hours and unreasonable workloads. This is particularly relevant in nursing.

We believe that childcare services generally must be seen in a broader context of overall services for children. An integrated and coordinated policy approach is required. A review of current programs needs to be undertaken with a view to improving coordination of services between agencies. For example, it may be possible and indeed cost-efficient and effective to facilitate the employment of nurses in child care centres for the purposes of health screening, promotion and immunisation.

It is the needs of children that should be central. Care, education and health services must be designed and funded to meet **their** needs (and the needs of their parents) at the varying stages of their development.

Recommendations
The QNU recommends that the Minister: • Continues the current childcare flexibility trial to increase employee access to childcare services particularly during non-standard hours; • Gives particular consideration to the specific childcare needs of nurses and other shift workers and develops strategies to ensure that improvements to services for these workers is a priority area for government policy; • Adopts a 'whole of government' review of the childcare needs of departments/agencies employing shift workers with a view to improving child-centred service delivery.

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Attachment 1

Your Work. Your Time. Your Life.
Comments regarding flexible hours of work, availability of leave, shiftwork and child care

Flexible hours of work to meet need

- When I cared for my mother at home I got everything in Roster and time off I needed.
- Limited available childcare limits the hours I am available to work - but the rostering is always sufficient to enable me to fit in when I am able.
- I work night shift because my husband doesn't work locally, I am therefore here to take my children to and from school.
- My parents aren't that dependent only when they need driving to doctor appointments in Brisbane so far I've been lucky & have these days off.
- My husband is a shift worker and I work on his days off, while he cares for our children. This limits the days I can work per week.
- Never had to access the above in last 5 years but prior that time, staff were willing to swap shifts to care for children's needs and I do the same for others now.
- Modify my roster to suit partner's availability to care for dependent family members so that I can work. e.g. can work all shifts (am/pm/night) when partner is home, limited when partner is away.
- I work part time in order to be home / available for the kids.
- Management has been family friendly in allowing me to start work earlier in order to be able to collect children from school, i.e. 06:30 - 15:00 instead of 07:00 - 15:30 hrs.

Family/carer leave available

- We have family leave available.
- Never needed to but feel I could.
- If he's unwell and can't go to day care my husband and myself have to take turns to take family leave.
- Yes, I can take family leave when children are sick, but management let you know that they don't like it e.g. make you feel uncomfortable about it.
- Inadequate leave available when death occurs - 2 days for unexpected death of young mother. Told to use my holiday pay after 2 days.
- My employer has been outstanding in family friendly practices such as rostering and family leave.
- Can take family leave if needed but am generally not replaced at work.
- Need to take/plan family leave to suit responsibilities not always able to drop & run.

- I have an ill daughter who has only been diagnosed within the last 4 1/2 years. She has a life threatening syndrome which has seen her admitted to ICU three times in these past 4 1/2 years and transferred to Brisbane PA for a fortnight. I was able to take sick leave and family leave for this. I was the only one earning at this stage and had to work and be her full time carer as well. It was very stressful.
- Often made to feel guilty & have to justify your need to utilise family leave - at supervisory level not NUM level.
- I feel supported for the odd occasions that family leave is taken
- Only 5 days per annum

No leave entitlements

- I have requested family leave once in 23yrs (2/09) and this was denied
- This type of leave does not exist in the hospital I work in that I know of.
- When my mother was dying my application for family leave was not approved. I enlisted legal advice.

Inflexibility of shift hours impacts on employability

- Do a lot of night to help and remain on 3 shifts/week and will do more if not needed at home.
- I travel 1 1/2 hours each way to get to a workplace that allows me to work day shifts only as I am a single parent, living rurally with 2 young children. The local public hospital has policy that it is mandatory to work all 3 shifts, plus weekends. I am a highly qualified nurse, and my place of employment, a private acute hospital allows me to work suitable hours to be flexible with my capacity to work. Very frustrating to drive past an understaffed hospital because of their outdated policy!!
- I worked casual for 5 years 04-09 because of inadequate care arrangements for children before and after school as well as family/sport commitments. I chose this as a way to fit work to family commitments. Rotation rosters are difficult to manage. I looked for set days.
- Would love to work early shifts however, my workplace is not flexible to starting/finishing as I would have to be able to pick children up from school. Therefore have been on evening shifts for 12 months now. Miss spending time with my family.
- Annual leave requests are not granted until very near date requested. Rosters are out only one week ahead at times.
- Child care is always considered on top level priority this is only in theory & only on welcome speech/introduction but in reality that never happens. I believe proper law should be implemented for this. Some managers can accommodate child care request on top level. But some managers are like a rock, proving they are incapable for what they should do through them.

- My children have to wait at the bus stop from 3.30 until I get there at approx 4.15pm. Sometimes I'm off later. No relatives in town - live out of town.
- Inadequate childcare available in town - need to work less.
- As my husband travels with his work and we have no family available to help my hours are sometimes limited to within school hours - A 6 hour day suits me much more than 8. That is why I work mostly part-time.
- Despite my workplace knowing that I have young children and my husband being a shift worker, and clearly indicating my availability I am rostered to shifts I am not available to work and it is left up to me to swap shifts.
- Very difficult to get day care to suit shift work and you must leave to pick up your child as I have no family here to help.
- QLD Health advocate family first. This is not so when I have to work 3 night duties or 5 late shifts in a row and my granddaughter literally is given to her aunt and uncle for them to care for.
- My daughter goes to childcare Mon to Wed and I just hope I get work on those days. I can only work earlies. I need more work and more job security but they state I need to be more “available” and able to do all 3 shifts. I am a single mum and this is not possible. If I don't get work on those days my daughter has to go to childcare anyway as you are only allowed 20 absences a year."

Onsite childcare would help limit need for family leave

- It would be good if there were on-site child care 24 hrs/day this would help many hospital staff. So staff aren't rushing to get to day care facilities before they close as sometimes emergencies do happen & people have to stay back. Hospitals would also be able to retain staff as people wouldn't have to leave to look after their children - they would have a choice.