



australian
nursing federation

Award Modernisation

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1. Introduction

The Australian Nursing Federation (ANF) makes the following submission to the Australian Industrial Relations Commission (AIRC) for the purpose of deliberations on the shape and scope of modern awards covering nursing employees in the health and welfare industries as part of the second stage of the award modernisation processes.

This submission is to be read in conjunction with our earlier submissions filed with the industrial registry in June 2008 as part of the initial award modernisation consultations by the AIRC.

This submission and those filed earlier support the continuation of historical arrangements of occupational awards for nurses. It is the firm view of the ANF that the health and welfare industries are best served by maintaining the status quo of covering nursing work by nursing occupational awards.

1.1 Executive Summary

It is the submission of the ANF and the strong view of the nursing profession that nurses, recipients of care and the community generally will benefit from the continuation of nursing occupational awards.

Conversely it is the submission of the ANF that new modern awards made on an industry basis will have a negative effect on parts of the industries, will create artificial distortions in the labour market and consequently hamper the ability to provide the levels of services the public expects.

The proposal by the ANF for a new modern occupational nursing award to replace around 100 federal awards and NAPSA's is consistent with the Ministerial Request, accords with the requirements of Part 10A of the Workplace Relations Act 1996 and meets the limited principles and guidelines in the Full Bench Decision of 20 June 2008.

In the 30 years that nursing federal awards (and much longer for the previous state instruments) have operated there has been little disputation regarding their interpretation and application. Further there has been minimal if any attempts by employers to alter the content of the awards.

This history in part demonstrates that there is an acceptance by nurses and their employers that the extant nursing safety net awards reflect appropriate minimum conditions and are understood and applied in workplaces across industries where nurses are employed.

Nursing makes up 55% of the health and welfare workforce and is recognised as highly mobile across all sectors of nursing employment.

There is no feature of the nursing workforce that is currently demarcated on the business of the employer. Educational, clinical, registration and training standards are consistent wherever nurses may be employed. The agreement of the commonwealth and all state and territory governments for national nursing registration in 2010 is characteristic of the community and industry view that “a nurse is a nurse is a nurse”.

In the submission of the ANF there is no case to support a different award safety net for nurses based on the business of the employer.

1.2 The role and interests of ANF and its members

The ANF has the most extensive interest and coverage of all of the employee and employer organisations who have indicated an interest in the making of new modern awards in the health and welfare industries. The ANF represents as members over 170,000 nursing staff employed across the breadth of nursing in all the states and territories. Our membership is aware of the award modernisation processes and supports their unions’ approach and preferred outcomes. Their view is evidenced in the resolutions of annual branch conferences which form Attachment 1 to this submission and by the 7,320 nurses who have signed a petition calling for the continuation of nursing occupational awards.

2. An exemplar nursing occupational award

Attachment 2 to this submission is an exemplar nursing occupational award prepared on a without prejudice basis by the ANF to illustrate one approach to the scope and content of a new modern nursing occupational award. The draft award has been prepared to facilitate discussions between the industrial parties and to negate a number of claims in opposition to an occupational award.

The list of awards used in the drafting of the exemplar award forms Attachment 3 to this submission. Federal awards and NAPSAs from each state and territory have been used.

The draft award reflects existing safety net provisions and where this is not possible establishes new safety net provisions and identifies the extent of the differences in the current safety net provisions.

3. The demographics of nursing and nursing services

In this part of the submission we provide demographic information regarding the nursing workforce and the industries in which nurses are employed.

In our submission an understanding of the relevant demographics and the associated industrial and workforce trends is relevant to the criteria in section 576B(2) and paragraph 3 of the Ministerial Request and is important to the broader deliberations by the AIRC of a move away from occupational awards to industry arrangements.

3.1 Who are Nurses?

Nurses form the largest health profession, providing health care to people across their lifespan. They work independently or as collaborative members of a health care team in settings which include hospitals, rural and remote nursing posts, indigenous communities, schools, prisons, aged care homes, the armed forces, universities, mental health facilities, statutory authorities, general practice offices, businesses, professional organisations and peoples' homes.

Nurses work to promote good health, prevent illness, and provide care for the ill, disabled and dying. Nurses also work in non-clinical roles to educate new nurses, conduct research into nursing and health related issues and participate in developing health policy and systems of health care management.

3.2 Nursing practice in Australia

Nursing is a regulated profession. By law, before nurses may practise, they must be registered, enrolled, endorsed or authorised by their state or territory nursing and midwifery regulatory authority (NMRA). The titles of 'registered nurse', 'enrolled nurse', 'midwife' and 'nurse practitioner' are protected by legislation, and these titles may only be used when permitted by the state or territory NMRAs.

Another group of health care worker, assistants in nursing (AINs)¹, also delivers aspects of nursing care and are an integral part of the nursing workforce. Assistants in nursing do not yet have a consistent minimum standard of educational preparation and are not regulated by the NMRAs however their relationship with others is regulated.

3.3 Nursing Education

Registered nurses must complete a three year bachelor degree at university before they are eligible to register with their NMRA. They undertake a period of post-registration graduate support in a hospital, usually a year, and then go into general nursing practice. They may also undertake postgraduate study to specialise in one of many clinical practice areas.

Enrolled nurses are educated in the vocational education and training (VET) sector for one year to eighteen months, to either a Certificate IV or Diploma level, before being qualified to enrol with their NMRA. They may also undertake additional study to work at a more advanced level. In some states and territories, they are able to gain a qualification which enables them to administer some medications to patients.

Midwives either undertake a bachelor degree in midwifery, or are registered nurses who hold a recognised post-graduate midwifery qualification.

It is estimated that over 65% of the AIN workforce hold a Certificate III or IV related to their responsibility to assist in the provision of nursing care.

3.4 Nursing Workforce Numbers

With a combined total of 244,360, registered and enrolled nurses comprise over 55% of the entire health workforce².

A census of the nursing workforce is conducted every two years. The most recent figures were released in 2008, and cover the year 2005³: In 2005 there were:

198315	Registered Nurses
46044	Enrolled Nurses
18297	Midwives
200	Nurse Practitioners

¹ Assistants in nursing and other unlicensed workers, however titled.

² Australia's Health 2006, p 317.

³ Australian Institute of Health and Welfare (2008). Nursing and Midwifery Labour Force 2005. Canberra, pp 2, 6.

There are also around 68,500 AINs⁴ in Australia, who are mostly employed in the aged care sectors.

3.5 Other Nurse Demographics⁵

Over 62% or 152,890 nurses work in major cities. Just over 31%, or 76,270 work in regional and rural areas, and 6%, or 5,480 nurses work in remote or very remote areas.

The average age of nurses is increasing. The average age of employed nurses in 2005 was 45.1 years, up from 42.2 years in 2001. The proportion of nurses aged over 50 is 35.8%.

3.6 Occupational Identity

Diversity in nursing work is characteristic of the occupation, across an extraordinary range of employment/practice contexts with a primary and shared identity with the profession and discipline of nursing.

All licensed nurses are prepared for professional practice through nursing-specific courses and programs derived from the discrete knowledge base and discipline of nursing. This is well established in tertiary, post-secondary (TAFE) and accredited hospital/health service training institutes and centres.

Professional and industrial association for nurses is almost universally with discrete nursing bodies (Australian Nursing Federation, Royal College of Nursing Australia, Coalition of National Nursing Organisations, etc) preoccupied with the common occupational concerns of nurses, nursing work, health and health delivery systems.

All contexts of practice/employment for nurses constitute similar occupational habitat concerns for example: role development; ongoing education; research and knowledge generation; service delivery models and innovation in the delivery of nursing; safe, quality professional practice environments (reasonable workloads, safe skill mix, adequate recruitment and retention of licensed workers, safe workplaces; participatory mechanisms, nursing models).

⁴ Australian Institute of Health and Welfare (2006). Australia's Health 2006. Canberra: AIHW, p 316.

⁵ Nursing and Midwifery Labour Force 2005, pp viii, 12.

It is recognised that nursing identity derives from the core beliefs/values central to the role of nurse/midwife whatever the practice context. These are widely agreed and evidenced (in role statements, occupational research, international professional codes, statutes and regulations, policy and practice references) as knowledgeable human caring, professionalism, advocacy, and holism.

These tenets of the definition, intention, and outcomes of nursing identify the idea of the 'nurse', the role of 'nurse' and the discourses maintaining the existence, relevance, and the social contribution of the occupation of nursing.

The nursing discipline as a discrete and distinguishable body of knowledge, practice standards and work in various practice domains and specialisations, is the source of the nursing identity, its occupational existence, and its potential in meeting the nursing needs of people - individuals, families, and communities.

Nursing's professional obligation derived from nursing's collective ethic of care is first before all, to reproduce itself occupationally. This is essential in meeting the existing and increasing demand for the complex, knowledgeable, human caring that nursing provides for those who need nursing throughout their lives.

Nursing work, while flexible across professional boundaries and in meeting the unique needs of particular health service delivery contexts, (for example, remote, residential, clinic, outreach) can be regulated and managed precisely because it is distinguishable from the work of other health care providers. This is reinforced within a clear occupationally identified scope of practice with transparent processes of professional and public accountability. Nursing as an occupation is known and can be known as 'nursing'.

Nursing occupationally is recognised by the community as a highly regarded identity individually and collectively.

Nursing occupationally is recognised as highly mobile across employment sites.

Nursing occupationally is recognised as highly unionised with a well established capacity for professional and industrial mobilisation.

National and State/Territory regulation and professional governance is directed by bodies that are entitled (by State regulation and by professional entities) to govern both nursing and midwifery, for example, State Government Offices of Nursing and Midwifery; Australian Nursing and Midwifery Council.

4. The nursing shortage

Section 576B(2)(a) requires the AIRC to have regard to “*promoting the creation of jobs, high levels of productivity, low inflation, high levels of employment and labour force participation, national and international competitiveness, the development of skills and a fair labour market;*”

Aspects of s.576B(2)(a) are relevant to the consideration of the nursing labour shortage in the context of award modernisation.

Over the past decade a number of reports have been produced examining the nursing workforce and various specialist nurse workforces.

Although each of the national nursing workforce reports differs slightly in its findings due to the various data sources and methodologies, there are consistencies in both identification of key drivers of supply and demand and findings in terms of projected supply and demand. Essentially the “sign posts” are pointing in the same direction and each of the reports highlight the same factors. These include:

- the general inadequacy of numbers of nursing graduates produced over recent years to meet demand (in terms of both replacement and growth in demand for health services);
- the ageing of the nursing workforce (and projected retirements), decreasing hours worked and turnover and the effect on the ability of the nursing workforce supply to replace itself; and
- growth in demand for health services expected to increase especially in the aged care sectors but also across acute care sectors.

While there is some variation in the projected supply and demand in each report, they all show this shortage becoming more marked.

The reports also find that there is a shortage across all states and one which is more significant in the aged care sectors. The preference of nurses to work in acute hospital sectors with a younger workforce, the existence of comparatively low rates of pay (ie comparable EBA wage levels) and heavy work load requirements are factors which make nursing less attractive in the aged care sector.

Assessing the level of demand and the numbers of workers that are needed is not straightforward. While it requires sophisticated modelling, the estimated shortage for 2006 was between 10,000 and 12,000 nurses, rising to an expected shortage of between 10,000 and 13,000 in 2010 (AHWAC 2004).

5. [The health and welfare industry](#)

The term 'health and welfare industry' is a misnomer as it is rarely used and has little relevance beyond the AIRC panel system. A more accurate term to describe services and the coverage of awards within the grouping is the health and community services industry.

This is the term used by the Australian government, the Industry Skills Council and various state and territory instrumentalities.

The DEEWR divides the health and community industry into six broad sectors:

- Hospitals and Nursing Homes,
- Medical and Dental Services
- Other Health services (including Pathology , Optometry Ambulance Services, Physiotherapy , and Chiropractic)
- Veterinary Services
- Child Care Services and
- Community Care Services.

On the basis of this definition in February 2008 the health and community services industry employed 1,124,500 people or 10.6 percent of the total workforce and was the third largest industry in Australia.

The July 2008 DEEWR industry report on the employment demographics of the industry forms Attachment 4 to this submission and can also be found at www.skillsinfo.gov.au

6. Aged care

Aged care services play a central role in the delivery of health care services in Australia. Aged care covers a number of services ranging from those provided in residential aged care facilities and acute hospitals, through to community health services such as home and community aged care programs (eg home help, home nursing services and home and centre based respite care) .

Arrangements for the provision of aged care services are complex and varied with all tiers of government involved either as regulators, providers of care services, or both.

As the table below shows in 2007 the main providers of residential aged care services were religious organisations (29%), private for profit providers (27%), community based providers (17.5%) and charitable organisations (15%).⁶ In addition the federal government, state and territory governments and local governments also provided over 11% of the total number of aged care services.

Table 2.4 **Ownership of residential aged care facilities**
As at 30 June 2007

	Number of facilities	Per cent
Private not-for-profit	1762	61.4
Religious	827	28.8
Community-based	504	17.5
Charitable	431	15.0
Private for-profit	773	26.9
Government	337	11.7
State/ Territory	262	9.1
Local	75	2.6
Total	2872	100.0

Source: AIHW (2008d).

⁶ Productivity Commission 2008, *Trends in Aged Care Services: some implications*, Commission Research Paper, Canberra, page 16

In 1995 there were 134,810 residential aged care places, 2005 161,765 places and in 2006 there were 166,291 places.

This growth is expected to continue as a consequence of the aging population. During this period there was also a steady increase in the proportion of residents classified as requiring high levels of nursing and medical care. Between June 1998 and June 2007 the proportion of high care residents increased from 58% to 70%.⁷

These trends demonstrate that residential care places have been progressively provided to more people and those people are more dependent on nursing care.

The numbers of registered and enrolled nurses employed in aged care has fallen by 42112 in 1995 to 34031 in 2005 a decline of around 20%. Over the same time the number of residential aged care places has increased by 23%.

The decline in the number of registered nurses was highlighted in the AIHW Nursing Labour Force 2001 based on 1999 figures. It reported that the substantial skill loss resulting from the loss of registered nurses from this sector and the increase in dependency levels places further pressure on the residential aged care sector.

During this same period, the supply of Community Aged Care Packages, aimed at providing the equivalent of low care residential support to people living in their homes, has expanded significantly and now represents around 16% of all aged care services.⁸

This pattern is in keeping with established bi-partisan government policy, which aims to provide a greater proportion of aged services to people in their homes.

6.1 The nursing workforce in aged care

Provision of nursing care in residential aged care ranges from the provision of basic care, such as the washing and dressing of residents, feeding, toileting, changing linen and the maintenance of skin integrity, to more complex or technical care such as medication delivery, continence care, oxygen therapy and tube feeding, stoma management,

⁷ AIHW Residential aged care in Australia 2006-07 at page 48

⁸ Productivity Commission 2008, *Trends in Aged Care Services: some implications*, Commission Research Paper, Canberra, p.22

insertion of intravenous and naso-gastric tubes, dialysis management and complex pain management. The range of duties performed by the nursing care team can be extensive. The demand for more intense nursing care increases with more complex cases and the increasing demand for beds.

Most aged care facilities operate by reference to a “Nursing Care Plan” or “Care Plan” identifying the nature of care to be provided to an individual resident and the most appropriate manner of the delivery of care. The “Plan” approach is adopted to ensure that a consistent and holistic approach is undertaken to the delivery of the care by all persons providing nursing care or services. Such a plan also enables the identification of any change or increase in the need for care.

6.2 Nursing skills mix in aged care

In the aged care sectors the work of registered and enrolled nurses is progressively being substituted by unlicensed workers, which now represent the bulk of the workforce providing aged care services.

A recent Australian study found skill mix was a significant predictor of patient outcomes. Reinforcing the findings of other international studies, a skill mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue.

The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients; one extra registered nurse per day would reduce the incidence of pneumonia by 16 per 1000 patients; one registered nurse per day would reduce the incidence of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing hours increase.⁹

Altering the skill mix of nursing staff in the aged care sectors is a practice which is clearly only motivated by desire among many aged care employers to drive down one of their major costs - that of staffing.

⁹ Duffield, C. et al. 2007. *Glueing it together: Nurses, their work environment and patient safety*, Centre for Health Services Management, University of Technology Sydney, Final report

It is in this context that many employers view the formal severing of the award safety net in aged care from the rest of the health sector as strengthening and legitimising their view that nursing care of the aged and infirmed can be provided at levels less than that provided in the acute sector.

In the absence of sound and robust evidence as to how aged care residents would benefit and how the community's expectations would be met by the establishment of an aged care industry award, this approach should be rejected.

6.3 Decline in the award safety net

Despite the notional obligation on the AIRC to establish and maintain a safety net of fair minimum wages and conditions of employment, award entitlements have been in decline.

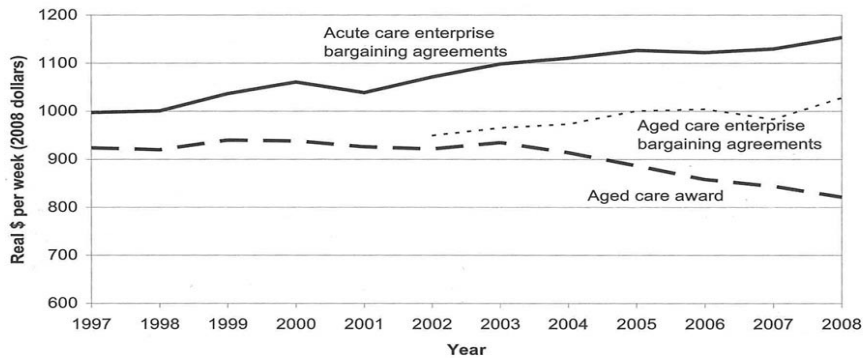
For the thousands of nurses who continue to rely on safety net awards the award modernisation exercise provides some hope that the deterioration in their award wages and conditions of employment that has occurred principally over the last decade will be curtailed.

This decline accelerated upon the introduction of "WorkChoices" which radically altered the role of awards. WorkChoices introduced new legislative objects concerning the function of awards and the role of the Commission in relation to them. It significantly limited the extent to which awards could act as a comprehensive safety net of minimum working conditions by removing any reference to fairness and requiring that awards provide only 'a safety net of minimum entitlements'.

For nurses particularly those employed in the aged care sectors who have also been unable to reach an agreement with their employer the impact of the decline in the awards has been significant.

As the table below¹⁰ demonstrates the Productivity Commission has concluded that real weekly award wage rates (as adjusted by the GDP deflator) for a nurse (level 1 Year 8) employed in the aged care sector, are less in 2008 than they were in 1997.

¹⁰ Productivity Commission 2008, *Trends in Aged Care Services: some implications*, Commission Research Paper, Canberra, p.44

Figure 6.2 Comparison of registered nurse remuneration^a

^a Median national Registered Nurse (Level 1, year 8) wage in January of each year, adjusted using the GDP deflator.

Data sources: ABS (*Australian National Accounts: National Income, Expenditure and Product, March 2008*, Cat. no. 5206.0); ANF (Melbourne, pers. comm. 21 May 2007 and 16 June 2008).

As submitted earlier there has been a general unwillingness by aged care employers to embrace enterprise bargaining and one consequence of this, as demonstrated in the table, is a growing wages gap.

The structural labour cost advantages that aged care employers enjoy is something they wish to now embed through a new modern aged care industry award. They can confidently hold this view because there is nothing in the policies of the federal government that suggests that in future they will have to bargain with their employees.

A new modern aged care industry award will provide comfort to aged care employers that they can continue to decline to engage with their employees in bargaining.

In the respectful submission of the ANF such an outcome would be inconsistent with the Ministerial Request as well as s576A (2) (d) as it would not promote collective enterprise bargaining.

6.4 Bargaining in aged care

The extent, scope and content of agreements in the aged care sectors is relevant to the making of new modern awards for employers and employees in these industries.

Bargaining outcomes in the aged care sectors can be best described as patchy with collective agreements generally providing remuneration arrangements that fall well short of those provided for in both public and private acute health care settings.

While the content of federal safety net awards covering nursing staff in both the acute and aged care sectors remains broadly comparable, enterprise bargaining outcomes have led to significant differences in remuneration levels.

This difference is primarily due to the inability of aged care employees, including nurses, to secure comparable agreements to those in the acute sectors.

For example in NSW, where a State common rule award has been in place, that NAPSA still applies to approximately two thirds of aged care nurses and only a limited number of employers have engaged in bargaining. Those employers are mainly from the charitable sector with minimal participation by the private for profit sector.

In response to claims by employees and unions, employers have argued that enterprise bargaining is unsuited to the sector due to the lack of funding and the strict controls on the employers ability to raise revenue.

The aged care industry is primarily funded by the commonwealth and such funding does not recognise agreement outcomes.

The constraints of the funding arrangements and the employer's slavish reliance on such arrangements to decline to participate in meaningful bargaining with their employees have been subject to comment by the AIRC.

In granting a claim to adjust wages for nurses employed in aged care in the Northern Territory in 1999 a Full Bench of Munro J, Duncan DP and Eames C in decision Print S6646 stated:

***“The evidence before us in this matter justifies an observation that the RACFs in the Northern Territory are a particularly cogent example of not-for-profit private organisations partially dependent on public sector expenditure serving what is accepted to be a public purpose. There is an exigent and precarious character to these RACF's operations. In our view those considerations demand a close and sympathetic examination of the adequacy of the funding formula in application to these institutions.*”**

The circumstances in which these RACFs operate, and the needs that they alone provide services to satisfy, should attract a practical level of support. It is not consistent with equity and good conscience for a society, or for

that matter a government, to impose on those who staff such institutions an undue degree of responsibility for the dilemmas of funding and services that appear to be chronic. Nor is it consistent with good conscience to fail to address patent incapacity to deliver a relatively equivalent level of remuneration for work of equal value. Substantial differences which appear to exist in the effective remuneration available to professional aged care service providers in such institutions and comparable staff in other health and human services institutions in the public or private sectors. That circumstance should either be justified or redressed: it should not be simply ignored”

(at page 17)

and further

It is essentially unjust for the community to be so dependent on not-for-profit service providers and essential service nursing staff, but to fail to supply adequate funding to meet what we consider to be a base level movement in the rates of pay to ensure equitable treatment between comparable groups of nursing staff.

(at page 23)

That said it should also be noted that since 2002 there have been a range of funding initiatives by the commonwealth government directed at enhancing the capacity of aged care employers to offer competitive wages. These initiatives include \$211 million over four years in the 2002-03 budget and a further \$877.8 million in 2004. Unfortunately these additional amounts were not tied to wages and much of the money was used for other purposes.

The parlous state of bargaining in the sector has led to an inability of employers to fully compete in the labour market and they have struggled to recruit and retain nurses and other health professionals.

Establishing a new modern industry aged care award would be the antithesis to the promotion of enterprise bargaining. It would entrench a different and inferior set of employment conditions for aged care employees.

6.5 Award Modernisation in aged care

The wide ranging services provided within the aged care sectors, the reduction in the numbers of nurses employed and the changing skills mix are all relevant considerations in the processes of award modernisation, in particular section 576B(2) and the terms of the Ministerial Request.

In our respectful submission the AIRC should not make new modern awards that will dissuade employees from entering or remaining within part of an industry. To do so would be inconsistent with promoting employment and workforce participation and therefore inconsistent with s576B(2)(a) & (f).

The making of a new industry award in aged care would accelerate and entrench the loss of qualified nurses, the inadequate skills mix and poor resident outcomes.

As previously noted aged care residents are increasingly requiring high levels of nursing care; they are frail, vulnerable people with multiple chronic illnesses and at a high risk of injury and side effects, who require complex medication and health care treatment regimes.

With the reduction in nurses and the consequent changes to skills mix, this is leading to a lower level of safety and quality of care and putting these vulnerable residents at risk.¹¹

The aged care accreditation data on failed standards reveals that this has led to a decline in quality of care with residents exposed to serious risk from neglect, poor infection control, malnutrition and dehydration, and assault.¹²

¹¹ Richardson, S. and Martin, B. 2004. *The Care of Older Australians: A Picture of the Residential Aged Care Workforce*, National Institute of Labour Studies, Flinders University, Adelaide.

¹² Department of Health and Ageing, Report on the operation of the Office of Aged Care Quality and Compliance, 1 July – 31 December 2007.

The community's increasing alarm with this situation can be seen not only in the regular media reports but also from the following figures: in just six months last year, the federal government's Office of Aged Care Quality and Compliance received nearly 4,000 complaints (more than triple the number of complaints lodged in the previous twelve month period) about the treatment of people that potentially breached the *Aged Care Act 1997*. This included 418 reportable assaults.¹³

There is a substantial body of research which demonstrates clear links between nurse staffing levels and the quality of nursing home care.¹⁴

The range of findings are summarised well in the 2005 study by Horn et al which found care delivered by registered nurses in aged care facilities was strongly associated with better resident outcomes: fewer pressure ulcers (a major risk factor for the frail aged); fewer hospitalisations; lower incidence of urinary tract infections (thus reducing the requirements for more intensive care, catheterisation, and antibiotic therapy); less weight loss; and a much lower risk of deterioration in the resident's ability to perform activities of daily living – vital to optimising wellbeing and health status.¹⁵

7. A nursing occupational award and pay equity

The continuation of nursing occupational awards is an important consideration for pay and gender equity.

S576B(2) (e) requires the Commission to have regard to “*the need to help prevent and eliminate discrimination on the grounds of race, colour, sex, sexual preference, age, physical or mental disability, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction or social origin, and to promote the principle of equal remuneration for work of equal value*”.

The undervaluing of women's work in general is a critical factor in the many battles for fair wages and conditions for nurses across the different areas of nursing employment. Nursing work remains under-valued despite various wage cases, industrial campaigns, the widespread shortage of nurses and the numerous reports, inquires and reviews into nursing and workforce issues identifying improvements in wages and conditions as key issues in recruitment and retention of nurses and attracting students to nursing education.

¹³ Ibid.

¹⁴ Zhang, N.J. et al. 2006. Minimum nurse staffing ratios for nursing homes, *Nursing Economics*, 24(2):78-95.

¹⁵ Horn, S., et al. 2005. RN staffing and outcomes of long term nursing home residents, *American Journal of Nursing*, 105(11):58-70.

In nursing, the under-valuing of women's work is one part (albeit a significant one) of the gender pay gap that has yet to be addressed.

Although highly regarded by the community, nurses are chronically undervalued by employers.

The enduring failure to remedy the situation has entrenched nursing recruitment and retention problems in all states and territories across the country, particularly in the aged care sectors.

The nature, size and distribution of the industry and profession also has led to limitations on the adjustment of nurses' wages because, unfortunately, the issue of costs has repeatedly been a feature in the fixation of nurses' wages, often regardless of other factors attaching to the valuation of their work. The fact that they are the largest single group within the health system has often put the brake on increases in award/agreements rates.

The acknowledgement of this by industrial tribunals is reflected in the history of the establishment and maintenance of awards and is significant because the history in part reflects the insistence of the industrial tribunals (particularly the AIRC) to establish and preserve distinct national nursing industrial standards.

While problems do remain many of the pay and gender advances for nursing that have occurred will be lost if nursing classifications are buried in generic industry awards where nurses become a shrinking minority.

The issues and concerns raised in this submission are similar to those raised by a number of significant women's organisations who jointly supported a statement that appeared in a number of daily newspapers on 30 October 2008. A copy of that statement forms Attachment 5 to this submission.

Finally on this point we recognise that the AIRC is to have regard to the needs of the low paid consistent with s576B(2)(c). And we note that a significant proportion of Assistants in Nursing employed in aged care are in this category. They earn as little as \$16 per hour and are predominately female.

8. The nursing vs care debate & avoiding the overlap

A number of organisations have sought to portray the ANF support for nursing occupational awards as an attempt by the ANF to extend the scope of our traditional award coverage.

This claim doesn't stand up to even a cursory examination.

In the initial submissions of the ANF the following scope for a new modern nursing award was proposed:

The scope of an award to apply to the occupation of nursing shall apply to all persons who are primarily employed to provide or assist in the provision of nursing care and/or nursing services. Nursing care and nursing services encompass any care or services provided in the course of the provision of care to persons in need of medical or health care and/or in need of assistance in daily living.

As stated in the initial submission the draft scope was intended to encompass employees who are primarily employed to provide or assist in the provision of nursing care and not to apply to employees who may undertake tasks or responsibilities that are subsidiary to providing nursing care or nursing service. It was also stated that such employees are registered nurses, enrolled nurses, and assistants in nursing.

These employees are currently covered by nursing federal and state awards to which the ANF is a respondent.

The terms of the draft scope are consistent with a number of decisions of the AIRC and the courts generally. Examples are set out below:

In an application pursuant to s.111(g) the Health Services Union sought the dismissal of an application by the ANF under s204 in part on the grounds that;

“The HSUA contended that there are two instances of ambiguity in the proposed alteration. Firstly, it alleged that it is unclear what is meant or intended by the terms “nursing care” and “nursing services” when read in the context of the eligibility rule as a whole.

The eligibility rules provide for membership for persons who are nurses. If “nursing care” and “nursing services” are intended to mean something other than the work that nurses do, then that needs to be defined and the proposed rule alteration does not define it.

Secondly, it alleged that it is unclear what is meant by the term “to assist”. That term is not defined even in terms of the proportion of time that a person is to spend on “assisting”. Taken at its broadest, every employee at an establishment wherein professional nurses carry out their profession might be said to assist in the provision of nursing care or nursing services by keeping the facility going.”

(Print R7043 at paras 8 and 9)

In rejecting the application the AIRC observed:

“Further, in this particular case, there is nothing obviously vague or ambiguous about the proposed rule alteration. The terms and language used are not unusual and are capable of being given meaning. I cannot accept that the proposed alteration is lacking in precision merely because the HSUA may have some difficulty in deciding upon its meaning. The mere fact that the terms of a proposed rule may mean different things to different people is insufficient “

(Print R7043 at para 14)

In deciding the substantive application the AIRC made the following observations on the appropriate industrial interpretations of the term “nursing, nursing care and nursing services”.

- [37) *Having considered all the material before me, I am of the view that the appropriate approach, for the purposes of determining this application, is to give the terms contained in the proposed alteration a broad interpretation, constrained only by the context in which those terms appear. For that reason, I intend to interpret the term “nursing” as meaning providing care to the sick, infirm and/or those who, for any reason, are unable to look after themselves. I include amongst such persons those who are not only in need of medical care but also those who are in need of assistance for the purposes of daily living. Without attempting to provide an exhaustive list, I would identify the tasks performed by such persons as including bathing, showering, ensuring the hygiene of the immediate*

environment, changing beds and toileting, implementing nursing care plans, implementing appropriate behaviour management, dementia management, dressing and assisting in the dressing of wounds, identifying skin lesions or damage, identification of behavioural or health changes, observation of patients/residents and observation and supervision of other staff providing such care. Many of these tasks are, in my view, basic nursing tasks. They are tasks that may be performed by a registered nurse wheresoever employed. The terms “nursing care” and “nursing services”, would therefore encompass any care or services provided in the course of the provision of care to such persons whatever title is given to the person providing such care.

[38] *For the purpose of industrial or workplace relations, in the context of the provision of nursing care and/or nursing services to the residents of aged care facilities, it is, in my view, neither possible nor appropriate to distinguish between the nursing care and personal care. Such a distinction may well be made for the purposes of determining the levels of funding of residential aged care facilities.*

However, the evidence before me demonstrates that, for the purpose of the actual provision of care, the distinction is artificial. In this context, nursing care cannot be properly described as being limited to care of a medical nature. Personal care, or, as it was described by some witnesses, the provision of assistance with daily living needs, is but a part of the provision of nursing care.

(Print T4652 at paras 37 and 38)

There have been a number of decisions coming to the same or similar conclusions including: RANF ex parte NSW & Ors 167 IR 185, RANF v. Private Hospitals etc 1984 11 IR 220 and Decisions PR 953970 and R9776.

9. [The span of businesses in the health and welfare industries](#)

The claims by employers that parts of the health and welfare industries may be neatly segmented into clean and separate entities based on the industry of the employer is perniciously inaccurate.

It is the rule rather than the exception that employers in these industries have inter state/territory business interests spanning different parts of the industries.

Set out below are examples of the current range of services provided by major employers in the industries.

Healthscope

Healthscope is one of Australia's leading private healthcare operators and is the second largest private hospital provider. It manages hospitals within every state and territory within Australia. Healthscope owns and operates psychiatric, medical/surgical rehabilitation and psychiatric hospitals. It has 2,400 beds and 2,000 employees. In addition, it operates a leading pathology business with facilities throughout Australia, New Zealand, Singapore and Malaysia.

Ramsay

Ramsay Health Care operates over 100 hospitals and day surgery facilities nationally and internationally and is Australia's largest private hospital operator.

Ramsay Health Care facilities provide a range of health care needs from day surgery procedures to highly complex surgery, as well as psychiatric care and rehabilitation. With over 8000 beds, the Company employs almost 25,000 staff across three countries.

Little Company of Mary

Little Company of Mary Health Care (LCM Health Care) is a Catholic not-for-profit national health provider that offers a broad range of health and aged care services in five States and Territories - NSW, Victoria, Tasmania, South Australia and the Australian Capital Territory (ACT). There are about 3,600 full time and part time staff.

LCM health care services include public and private hospital care, acute and sub-acute care, and retirement and aged care services. Other health care services include specialist, sub-specialist and general medical and surgical services, maternity, rehabilitation, alcohol and other drugs, breast screening, outpatient medical and allied health services, emergency departments, inpatient and outpatient mental health services, community based palliative care and rehabilitation, respite care, artificial limbs services, community nursing and other outreach services.

Catholic Health Care

Catholic Health Care, is the largest non-government provider grouping of health community and aged care services in Australia. Catholic Health Care represents about 13 per cent of the health care industry - 21 public hospitals, 54 private hospitals, and more than 550 aged care services.

Uniting Care Australia

The Uniting Care network is one of the largest providers of community services in Australia, providing services to 1.8 million Australians each year, employing 35,000 staff and 24,000 volunteers nationally. It provides services to older Australians, children, young people and families, Indigenous Australians, people with disabilities, the poor and disadvantaged, people from culturally diverse backgrounds and older Australians in urban, rural and remote communities.

In NSW there are about 2000 nurses under the Public Health System Nurses' and Midwives' (State) Award who work in hospitals/facilities known as Affiliated Health Organisations (AHO) There are currently 16 AHOs.

These AHO hospitals/facilities are considered part of the NSW public health system but are in the federal system. They include: St Vincent's Hospital Sydney Limited; The Sacred Heart Hospice; St Joseph's Hospital Limited; Karitane; Calvary Health Care Sydney Limited; Mercy Care Centre Young; Newcastle Mater Misericordiae Hospital, Waratah; Hope Healthcare [trading as: Neringah Hospital, Wahroonga, Greenwich Hospital, Greenwich, Graythwaite Nursing Home, North Sydney, Braeside Hospital, Prairiewood, Northern Beaches Palliative Care Service, Mona Vale]; Mercy Health Service Albury Limited; Royal Society for the Welfare of Mothers and Babies (known as Tresillian Family Care Centres, Belmore, Nepean, Willoughby, Wollstonecraft) and others.

NSW Health Policy Directives, Determinations and State legislation operate in conjunction with the state award. These instruments comprise their safety net of minimum conditions.

There is a Subsidy Agreement between NSW Health and each the AHOs which in part provides that employees are to be paid no more or no less than public hospital employees.

Victoria public sector

All Melbourne metropolitan public health services have acute and aged care , psychiatric and palliative beds.

The majority of aged care in rural Victoria is delivered by public sector health services or not-for-profit hospitals (bush nursing) in conjunction with acute and mental health.

A list of public health entities in Victoria which also operate residential aged care facilities forms Attachment 6 to this submission.

Victorian private sector

Several metropolitan, private hospitals provide additional services, including Cabrini, The Bays, Vaucluse, and Mercy Health & Aged Care which are major providers of aged and acute services across Victoria.

10. Conclusion

In conclusion this submission, along with materials filed by the ANF earlier in these proceedings provide, in our view a number of convincing reasons why the AIRC should support a new modern occupational award for nurses.

It appears to our union that the principal argument of employers in their support of industry awards is that this may reduce the number of awards applying to their particular business. While a reduction in the numbers of awards is one object in the award modernisation processes this does not, and should not, take precedence over the industrial and public interest benefits of an occupational award for nurses across all settings, which provides a consistent and fair safety net of minimum terms and conditions of employment.