

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warragul — 8 December 2017

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Witness

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The CHAIR — I welcome to these public hearings Ms Jan Jones, coordinator, Graduate Diploma of Midwifery program and Bachelor of Nursing Practice and Bachelor of Midwifery program from the School of Nursing, Midwifery and Healthcare, Federation University. I am glad they do not put that in an acronym. Thanks for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I now invite you to make a 10-minute contribution, and then we might have a discussion and ask some questions, if that is all right.

Ms JONES — No problem. I was not sure if you wanted copies of the presentation.

The CHAIR — We would love copies of the presentation, thank you very much. It will stop us craning our necks today.

Ms JONES — That will probably make life a little bit easier.

Visual presentation.

Ms JONES — For a start, thank you on behalf of Federation University for inviting us to present about this. Midwifery education is a big deal to us. We are quite passionate about it. I am worried that I might forget to tell you something, but anyway, we will see how we go.

The CHAIR — If you do, there is always a course for us to come back and give you a call.

Ms JONES — Okay, fantastic. Regarding the terms of reference, we are addressing points 5, 6 and 7 today. We think they are probably the most appropriate ones to be looking at. Just to explain a little bit about how we came to be, the University of Ballarat has offered the Graduate Diploma of Midwifery since 1996 and in that time has graduated around about 325 midwives. Prior to being Federation here in Gippsland, we were the Gippsland campus of Monash University. We have offered the Graduate Diploma of Midwifery since 2000 and have graduated around about 150 midwives from that program. In response to requests from industry, we started the double degree of nursing-midwifery in about 2008. That was in an effort to fill EFT. There was a huge shortage of midwives, which seems to be pretty cyclical in Victoria. We did manage to fill a lot of the vacancies with our graduates, which was fantastic. There are around about 25 grads a year, so we have graduated about around about 150 graduates from the double degree. I think we can all agree that a sound education is pretty important to producing a capable workforce.

Federation University came into being on 1 January 2014 with the amalgamation of the University of Ballarat and the Gippsland campus of Monash University. We are no longer offering the Bachelor of Nursing-Bachelor of Midwifery at the University. That was a decision made by the powers that be. They wanted to run only one midwifery program, so for the double degree there was one intake in 2014, and those students are finishing this year. I personally think it is a shame, because they are absolutely outstanding nurses and midwives who graduate from that — and so they should be after four years of it. At Ballarat and Gippsland, we have been offering separate Graduate Diplomas up until this year. We wrote a new program last year, had it accredited, and it has been rolled out this year. It is the same program offered in western Victoria and over here in Gippsland now.

Ms McLEISH — Why were they separate diplomas?

Ms JONES — Because they were essentially different universities.

Ms McLEISH — Historical?

Ms JONES — Yes. And when we came together we still ran our separate ones until we got around to getting a new one sorted. We have a capacity to support about 40 students a year across that as full time. If it is part time, we have got the capacity to support up to 80 students. I do not want to waste a lot of time telling you stuff that you might already know. Are you familiar with the accreditation process required for nursing and midwifery programs?

Ms McLEISH — It would not hurt to run through it.

The CHAIR — If you could take us through it briefly, that would be great.

Ms JONES — ANMAC, the Australian Nursing and Midwifery Accreditation Council, is the body that is charged with accrediting programs, and there is a whole range of criteria that we have to actually meet. Besides the theoretical component, we need to demonstrate the ability to meet clinical needs, as in teaching students hands-on skills and those sorts of things. It is quite an extensive and exhaustive process. We got accredited at the end of last year, and we have accreditation for five years. I would like to mention that we were actually accredited without any amendments or anything. They were very, very happy with the program that we had put together. Our program is underpinned by the social model of health and it focuses on women-centred care, which are contemporary philosophies that guide midwifery practice. They do not always match up with reality, but that is what we teach. I will talk a little bit more about that in a minute.

Prerequisites for our current program are that potential students need to be registered nurses with AHPRA. They need to have had at least one year's acute clinical experience in recent times. They can undertake this program either over one year in the full-time mode or over two years in a part-time mode.

We have the option of employment or supernumerary models of study. The employment model means that the health service employs the student in the maternity service for around about three days a week for the duration of the program. The supernumerary model means they do not get paid. There are benefits and disadvantages to both, and I can talk about them a little bit more later. All of our places are CSP-funded, which has made it really attractive to a lot of students. Most postgraduate courses are around \$20 000, but with the CSP funding ours is about \$6500, so it makes it really affordable fee-wise for a lot of people.

Just about the different models, the employment model means it is more affordable for students because they are being paid while they are studying. It means they have much more exposure to maternity services. They are employed and they have much greater hours of experience, so by the time they finish they are actually very work ready. They do not really need a supported grad year or anything like that. They are very capable, confident beginning practitioners. Many of them are employed at the host venue after graduation. They have been employed there. Our program places the student with one particular hospital for the duration of their program, unless they need to go elsewhere for specific experiences such as special care nursery or something like that. But generally they stay with the one hospital. That means they are really embraced by the hospital, they are very well supported, and it is something that is promoted within hospitals to grow their own, so they try and get their own current nurses to enrol in it.

The supernumerary model has some advantages in smaller hospitals in that if a hospital has a maternity service that is all on one ward, the student in a supernumerary model can then go to an area where they need experience if there is some action happening there. That is no benefit when it is a larger institution where students rotate between antenatal, postnatal and labour wards. They do not get to go where the action is, because they are actually rostered to a particular area. It is less affordable because students generally have to work while they are studying. There are very, very, very few who can afford the luxury of just studying. So it makes it really quite difficult for a lot of people to afford.

Ms COUZENS — Does anybody pick that model?

Ms JONES — They do. Some of them who really desperately want to do midwifery will find a way to manage it, but it is a real struggle for them. It is not just financially draining; it is actually draining physically and emotionally. Because besides doing their study and trying to get their heads around all this new information and working in a new field, they are also working their other job, so they are tired. They are split between them. They have got to try and work their roster around it. They sometimes have to take leave without pay or use their holidays to do their clinical placement in midwifery, so it is really, really challenging.

The CHAIR — So the quality of that clinical placement would suffer as well.

Ms JONES — I don't think the quality does, but there is not so much of it. When it is in a supernumerary model, the university has to pay for the placement. So they are going to pay for the minimum amount that they can. Our program has 720 hours of placement. The university has to pay for every single one of those hours. In the employment model, we don't, because the student is actually employed by the health service. They are part of the workforce generally, so we do not need to pay for placement. It is more affordable for us, and it is more

affordable for the student. But I have got to say the quality of the experience they get is the same, whether it is supernumerary or paid. They just get more experience in the paid model, which really tells at the end.

Ms COUZENS — Is there a reason why they would pick the supernumerary?

Ms JONES — Only because they cannot get a paid place. Almost every student would take a paid place if they were offered one, and there are lots of constraints around that. Because it is a paid place, there has got to be EFT in the roster at the hospital. If there is not any or if there is not enough, then they cannot put a student on. If there are no paid places, then students really can only do the supernumerary model. It just says something for their passion to do midwifery that they will actually do that. They will just suck it up for a year or two and get through it.

As I said, students are placed at one venue for the majority of their program. Our program is offered essentially online, with two intensive study blocks per semester. If it is a part-time student, they come for three days per study block; if they are a full-time student, they come for all five days of the study block. We have a lot of interaction through webinars and online classes and things through the rest of the semester. It works really well for students who live a bit distant from the university and it works well for people who have got lots of other commitments. They know they only need to come to uni for that time and they have to work around that because the study blocks are compulsory. It gives them a bit more flexibility in trying to work out their clinical placement as well.

Unlike nursing, midwifery education requires students to actually achieve a minimum number of specific experiences, and this is very onerous on students. This has been debated many, many times and refined and refined. It does produce very capable students but it means that students are often chasing numbers rather than the inherent experience itself. For example, they need to be the primary accoucheur, or the baby catcher, for at least 30 normal births, and then a further 10 births where they are with the woman. They might be with the woman for eight hours in the labour ward. They may not be there for the birth but they have been there for the labour. They need 100 antenatal assessments, 100 postnatal assessments, 20 full baby newborn baby checks.

One of the most onerous things that they need to do is called continuity of care experiences. These are where students engage with women early in their pregnancy and follow them through. They go to a minimum of four antenatal appointments and scans, are with the woman during the birth, if that is what the woman chooses, visit the woman postnatally and then attend the four-to-six-week check at the end as well. Now students need to do that for 10 women as a minimum. That can have quite an impact on students, particularly in rural areas, because they can be travelling —

Ms BRITNELL — In one year?

Ms JONES — If they are doing it full time; over two years if it is part time. But, yes, in one year if it is full time.

So in addition to their work and their clinical experience and their study and everything else that they need to, for these 10 follow-through experiences students will sometimes have to travel quite a long distance for a 15-minute appointment. It is financially difficult for them and time wise it is really difficult for them. It also means — of course there is very little public transport — that they need access to their own transport. For some, particularly the young ones, it can be a little bit of an issue.

For the clinical placement, that depends on their venue, whether they only offer blocks of time, as in weeks at a time, or whether they are happy to offer a flexible mode, which is perhaps two to three days a week over the semester. We have no control over that; it is basically what the venue is willing to offer. Some students just have to try and manage it. It is a really, really tough year for them, if they do it full time, particularly.

Students get experience in all areas of maternity care, so antenatal, postnatal, labour ward, birth, special care nursery — looking after sick babies — domiciliary, breastfeeding. Any area that has midwives, the students will be getting some experience in. Our program is basically broken down into six units or courses, whatever you like to call them. Two of those are quite large courses. The first one, dealing with normal pregnancy and birth, requires 200 hours of clinical placement. They look at public and primary healthcare in midwifery — 160 hours of clinical placement in that one. Then there is the midwifery profession and governance. In semester 2 they are

looking at complex pregnancy, birth, postnatal and the unwell neonate, so that is 120 hours in maternity care and 80 hours in a special care nursery looking after sick babies.

Evidence-based practice: in this unit students are actually required to conduct a small research project at the venue where they are doing their clinical placement. It is actually aimed at changing practice. So it is looking at things that are currently being done in a particular venue that perhaps has not had change for a while. The student needs to research that and then develop some sort of program that is aimed at changing the practice at that venue.

Diversity of midwifery practice is about vulnerable populations, Indigenous women, family violence, child protection, all those sorts of things. All parts of our program aim to foster critical thinking, reflective practice and lifelong learning. That underpins absolutely everything that we teach.

The benefits of our program as it stands at the moment is that we have excellent partnerships with our clinical venues. We have very longstanding partnerships with clinical teachers who have got great experience, and because of that we are able to identify pretty early any students who are struggling and put some strategies in place to try and help those students, so that every one of them is given the best opportunity to succeed.

We contribute to offering continuing professional development for midwives in the area, and I will talk a little bit more about that in a minute. There has been a grow-your-own attitude from local health services for many, many years. There is a lot of evidence that shows that for people who grow up in an area if they can undertake their education in that area, they are more likely to stay practicing in that area. Many, many of the health services that we work with would much prefer to use local students because they figure in the end those students might stay, and that is the whole point of actually offering a clinical place to a student. I can say with absolute confidence that in many of the health services in western Victoria and here in Gippsland we have actually produced the bulk of the staff who are currently practicing. I do not have any figures on that at the moment. A few of them are off on maternity leave, surprisingly, but every time we do a site visit a good half of the staff on the shift are previous students.

Students are owned by the health service, as I said earlier, so they are embraced and supported by the health service. They are given every opportunity. They are called in for births. They are given all sorts of access to all sorts of good experiences. Because of the structure of our intensive study blocks, it is good for rural students to be able to make it to uni.

We have got a few challenges and these are ongoing. Clinical placement is always an issue. If it is the supernumerary mode, we need to pay for every hour that student spends at the clinical venue, and that is a huge cost to the university.

Ms McLEISH — Can you explain that? What do you mean?

Ms JONES — We pay the venue to have the student there.

Ms McLEISH — Every hospital?

Ms JONES — Every hospital.

Ms McLEISH — You have to pay them for the honour of somebody volunteering?

Ms JONES — We have to pay them, yes. It is their —

Ms BRITNELL — Supervised.

Ms JONES — Yes, they need to be supervised.

Ms McLEISH — You are paying for the supervision.

Ms JONES — Yes, we are paying for the supervision essentially. So basically for the role of the clinical teacher, who may supervise them directly or indirectly. We do need to pay for every hour.

The CHAIR — That is the same with quite a few sectors as well.

Ms JONES — We do have difficulty accessing clinical places at times. When we ran the double degree here, particularly in Gippsland — we have not run it in western Victoria but in Gippsland we ran the double degree from 2008 — all of our students were basically placed in this area. Since we have stopped offering the double degree we had hoped that might offer more places for the postgraduate program. That has not really happened, but other universities are moving in and they are using the clinical venues. That has made it a little bit difficult for us to access clinical places at times.

The other difficulty is that trying to access tertiary centres — places for students — has been almost impossible. We have a couple of places where we have been able to get placement. The Royal Women's and the Mercy have agreements with another university, and they will not place any students, which we think is really unfair because when referrals are made, the women and babies usually go to the Mercy or the Women's. We have had some placements available at Monash Medical Centre, which has been fantastic, but they are very limited and basically we get what is left over that no-one else wants.

The supernumerary models are not affordable for many students. In this area we have used the paid model for a very long time, and it has been very successful. This year because of the new EBA arrangements some health services are not putting students on. Even though there is a training and development grant available, they are not putting students on because there are all sorts of extra requirements under the new EBA and so they are only offering places for students in the supernumerary mode, which gives an income to the hospital but does make it really difficult for the students.

There are a really limited number of models of maternity care across Victoria. Most of them are basically a biomedical model or an obstetric model, which is kind of in opposition to what we teach and in opposition to a midwifery philosophy. That can be really disheartening for students. We are sad we have got unhappy students. The thing is, when they come out of the program they are so passionate about midwifery and the difference they can make and how much better the experience can be for women, and then they get out into the real world and there are very, very limited options for them. A lot of that passion can be extinguished because they just feel like they are belting their head against a brick wall in a lot of places.

Having said that, there are some smaller hospitals in Gippsland particularly that are doing some fabulous stuff. Bairnsdale, for instance, offers waterbirth, which is not offered anywhere else in Gippsland. They have a midwifery model of care. There are a couple of those who have come and gone, but mostly it is basically a shared care or obstetric model of care. Our challenge is also to grow rural midwives. That is our whole point — to try and grow midwives who will stay in rural areas — and that is why we really support rural hospitals to try and engage their current staff to undertake midwifery.

The other thing that is a big issue for us as a regional university is the cost of guest presenters coming up here. We have a lot of industry specialists who come. The Fetal Surveillance Education Program is run by RANZCOG, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. It is a fantastic program, and it is offered at a very low rate year in, year out. It is quite affordable.

We used to use NETS, the Newborn Emergency Transport Service, now known as PIPER, but they have increased their costs over 100 per cent in the last couple of years, and we just cannot afford to use them anymore because they add on travel, accommodation and all that sort of stuff. I can understand that from a business point of view, but from an ethical point of view, the babies that need to be transferred will be transferred with PIPER. You need to educate rural practitioners on how to manage a baby, how to stabilise the baby and manage that baby until it can be retrieved, and if we cannot afford to have PIPER come out and teach students how to do that, that is going to be a real disadvantage.

We have looked at undertaking the facilitators program with PIPER, but they have told us that that is only available to people who are working clinically — directly. It is not available to educators, so we are going to have to try and work our way around that somehow. Next year will be the first year that we have not been able to use PIPER to provide that education, because it is just too expensive. A lot of other guest presenters will come for very little fee or for nothing, which is absolutely fantastic, and we are so appreciative of their efforts. There is not much more to say.

Regarding partnerships, we have a lot of really strong partnerships with all the health services, both in western Victoria and in Gippsland. MIDAC, the Midwifery Academics Group Victoria, is a group of midwifery academics in Victoria who came together a few years ago — quite a few years ago now — and we have worked

on projects together to try and develop guidelines or processes or paperwork that are the same across the board so that we can get some kind of continuity there. Together we developed a clinical placement portfolio. Some of the larger hospitals in Melbourne might have had students from five different universities, so they had five different kinds of paperwork to fill out. We have now got one uniform clinical portfolio that all midwifery students in Victoria use, whether they are postgrad or undergrad. The Australian College of Midwives is very strong in this area, and we have very good relationships with them.

The group I wanted to talk about in particular is the GMEAG group, which is the Gippsland Midwifery Educators Advisory Group. This group was formed about 15 years ago from clinical teachers in the area and has become a really strong group offering further education to midwives throughout Gippsland. It is facilitated by a clinical midwife consultant who works out of LRH these days. I think she is about the only one left in the state, but she does a fantastic job and she coordinates educational programs that upskill midwives in all sorts of different areas. That means they do not have to go to Melbourne. We can run these programs in multiple sites at multiple times so that everybody gets the chance to come. If they are working a late shift when it is on at their hospital, they can go up to Bairnsdale or somewhere like that and access it somewhere else. It has been a really successful model — minimal cost to the hospital, minimal cost to participants — and a great model for improving midwifery education not just for new graduates but for midwives who have been working in the field for a long time.

We work with the Koori maternity service. We do not place students with the Koori maternity service, but they are able to engage Aboriginal women for continuity of care experiences. The Aboriginal women are really keen for that to happen. When we can, we conduct interprofessional learning programs with the Monash University medical school in Churchill. We do family violence, fetal surveillance — whatever we can.

I have a couple of recommendations. Support for students is absolutely crucial, and I really cannot talk highly enough about the employment model. As I have said before, of those who cannot get an employment position some will be able to do it in the supernumerary mode and they will undertake that. It is pretty punishing for them. It is a very, very tough time, financially as well as physically, but the employment model has worked really well for many, many years, and I really endorse that model. I would like to see a lot more funding made available for it. As I said, at the moment it is only funded if the hospital has some spare EFT in their roster. That is the only way they can afford to put a student on.

We really need some more placement opportunities for students to go to tertiary centres or metro centres. We do have a few private metro hospitals that will take students for certain experiences, but we do not really have access to the big tertiary centres where women and babies get referred to, and the students just going to see what happens there is absolutely invaluable. They might be with a woman who has a baby. The baby is transferred to Melbourne, and then a week or so later it comes back. They have got no idea what happens to that baby or that woman in the meantime, and it is a real deficit. We can talk till we are blue in the face, but it does not explain it. It does not match up to those students actually going and seeing what happens. Getting access to some metro places would be absolutely ideal.

Some travel subsidies for guest presenters would be extremely welcome. There are not too many, but as I said, PIPER are the gold standard for neonatal stabilisation and resuscitation, and if we cannot afford to engage their services, that is going to be a real gap. I am not quite sure how we are going to address that yet.

We really do need to increase the models of maternity care available to women, including midwifery-led models of care. This is not for the benefit of the students — this of course is for the benefit of women — but students will benefit from accessing those models of care.

The other point I wanted to make was about research funding. Most research funding is directed at or claimed by large organisations in the metro area, and some rural areas will get some research activity as a sort of an offshoot of that. Bendigo Health, for example, does quite a bit, but particularly in maternity services, there is not a great deal of research going on in rural areas. Rather than being directed from the metro area, I think some of it needs to be directed from the rural area, because we have very different needs and we have different capabilities in rural areas. I think research into that is really important, but it is very, very difficult to access funding for that.

My final recommendation is to support ongoing education for rural practitioners. There are loads of midwives around the state who would love to engage in further education, but accessing it is really expensive. It is not just

about going to Melbourne for a study day. It is about the travel time, it is the time away from home and it is often accommodation as well. It ends up being a really expensive exercise both in time and in money. Far different from it being half an hour down the road, you can go for 8 hours and that works well. If you live in Bairnsdale, it is going to at least be an overnight stop and probably about 8 hours travel as well. That is about all I have got so far, so thank you.

The CHAIR — So far, Jan. I have got to admit, for me, you have answered a lot of the questions I had previously, and you have raised some questions too obviously in the last slide. So I am going to hand it over to Christine. I think Christine has got some questions.

Ms COUZENS — Thank you for your presentation today. I appreciate it. I have just got a few questions. What is the average age of the students?

Ms JONES — It varies enormously. In the double degree they were often school leavers or shortly after, sort of early 20s — not always, but mostly. For the postgraduate students they tend to be a bit older, but they do range from probably mid-20s up until even 55 or 60.

Ms COUZENS — What is the retention rate?

Ms JONES — I will talk about the Graduate Diploma. That is the only one we are actually keeping. It is very, very high. Occasionally we will have students drop out in the first semester because it is either a lot more than they expected or things are just not in the right place. Having said that, often those who do drop out early will just take a leave of studies and will come back. Once they have got things sorted they will come back the following year. We have very few who actually withdraw completely. Most of them complete their study if they start.

Ms COUZENS — And are they mostly from the region?

Ms JONES — Most of them are, yes.

Ms COUZENS — During that training do you have a focus on family violence, cultural awareness training and those sorts of things?

Ms JONES — We certainly cover that. Yes, absolutely. One of our six units that we work with is about looking at vulnerable populations. It is about child protection and family violence, all those sorts of things. We have engaged the Gippsland Women's Health Service previously to come down. They will do a fabulous seminar day where they include workers from all of those areas.

Ms COUZENS — And Aboriginal cultural training as well?

Ms JONES — Yes, absolutely. We have the Koori maternity service midwives and healthcare workers come and talk to the students. It is often really informal, but that is actually more rewarding. The students get more out of it, and they get to ask those questions that make you cringe but need to be asked.

Ms COUZENS — I know you have got a number of recommendations, and you have answered lots of my questions, but how do we engage more people to take on the training of midwives?

Ms JONES — I think in a lot of ways it is a bit invisible. The only one you see is *Call the Midwife*. We are not working like that anymore. I think in some ways it is invisible. It is a limitation in undergraduate nursing that most students do not get any experience at all in maternity care. They go to emergency, they go to crit care and they go to district. They go to all sorts of other areas, but they do not go to maternity care. I think that is a real deficit. That is where a lot of them will get a taste for it. The other one is where women might have had a baby or two and they have thought, 'I actually really want to do that. That sounds fabulous'. But midwifery does not have a high profile, and I am not quite sure how we raise the profile.

The CHAIR — A sitcom apparently.

Ms JONES — Okay. There is a nice YouTube clip that has got *Call the Midwife*, *Doctor Who* and something else mixed in. Google it. It is hilarious.

Ms COUZENS — So how many would you have coming out each year?

Ms JONES — With the graduate diploma, because our model is changing a little bit and we are no longer offering the double degree, our numbers are down a little bit. We are hoping they are going to increase. At the moment we are probably producing around about 15 midwives here and about 30-odd at the Ballarat campus. We are hoping to grow that considerably. We are hoping to have perhaps around 40 at each campus in the end.

Ms COUZENS — Is that sort of the average over, say, the last 10 years?

Ms JONES — That is more than we have done in the last 10 years. The University of Ballarat has graduated around about 17 to 20 per year for about the last 20-odd years. Here in Gippsland, with the graduate diploma we have graduated around about 15 a year. But with the demise of the double degree we are hoping that will increase to at least 20 a year.

Ms COUZENS — I suppose you would not have stats on how many of those are still working as midwives.

Ms JONES — No, I do not have concrete stats. Just anecdotally, I could not even hazard a guess how many, but I see —

Ms BRITNELL — AHPRA would have though figures, though.

Ms JONES — AHPRA would have those figures. Yes, they would for sure. I see lots of them around. I know some have moved out of the area, and some have moved out and come back.

Ms McLEISH — The grow-your-own attitude is one that we have heard quite a bit about today. It was in your slide as well. I think you mentioned that the majority of people that are undertaking your course are from the regions. The majority of people at this campus are from here and the majority from Ballarat are from around Ballarat. Is that right?

Ms JONES — Or western Victoria mostly, yes.

Ms McLEISH — I think the grown-your-own attitude is a great thing. But I look at football coaches. The say if you have been at one club and then you go into coaching at that club, you do not see what is out there. You do not understand the diversity that may exist and different techniques and different styles. How do you blend the two?

Ms JONES — That is a really good question. That is one reason we would like to get more access to metro areas so that students can get that opportunity. For a lot of the smaller health services we need to send their students elsewhere for the special care nursery placement. There are three special care nurseries in Gippsland, but we also access a couple in Melbourne as well. Over in western Victoria there are a lot of smaller health services that do not have special care nurseries, so the students need to go elsewhere for that. So they get exposed to a different work culture, if you like, by going to a different hospital.

The other thing is that for some of the smaller venues that have a lot of normal births and do not have much complexity, we will get those students a placement at a regional health service that is much more like a referral centre where things are a lot more complex, a lot more involved and quite different to what they are used to. On that same note, I would also like to send some of the students from the regional areas out to the smaller hospitals, because then they get to experience what a normal birth is, because sometimes in the regional areas it is a high-referral centre where there are a lot of high-acuity women and they do not actually get to see what a normal birth is very often.

Ms McLEISH — One of your recommendations was about accessing metro places, and you just talked about that. What is the barrier there?

Ms JONES — My understanding is that for the Women's hospital they only take students from La Trobe University.

Ms McLEISH — Yes, you mentioned that. The Women's and the Mercy both just take from La Trobe.

Ms JONES — The Mercy I think only takes students from perhaps Deakin and ACU. We do have access to St Vincent's Private, who have been fabulous over the years. With Epworth, we have used their special care nursery but not their maternity area. They only take students from La Trobe as well. That is a real limitation. There is a placement program in place, but not everyone works by the rules.

Ms McLEISH — One of the other recommendations is that research funding is available for rural and regional health services and universities. Where is the logical spot for that money to come from?

Ms JONES — I am really not sure. I am really not sure, because I know a lot of the —

Ms McLEISH — Is it federal funding or state funding?

Ms JONES — Either would be fine. A lot of federal funding goes into research, but usually that is quite large.

Ms McLEISH — That is right. That is what I was thinking.

Ms JONES — There is no way a smaller university or a smaller health service could actually realistically compete for that sort of funding, but smaller areas of funding, even for pilot projects, would be a really good start. But I just think some of this research needs to be driven from the rural location, not from metro and then sort of sourced out to the rural location. I think it has a completely different focus if it comes that way.

Ms McLEISH — Typically if you mention the word 'research', everyone says, without thinking, 'That's federal'.

Ms JONES — I guess so.

Ms McLEISH — But when you are looking at pilot programs and things like that, I am just —

Ms JONES — There are little buckets of money around. The old Victorian Nursing Council used to have different little research buckets of money — the Mona Menzies. They are only worth about \$5000 or \$10 000. We can access them and we can start things, but it is not enough to really drive anything very ambitious at all.

Ms BRITNELL — Cindy has already asked the question I was going to ask about. We have been hearing a lot that we cannot get enough midwives into the regions. Growing your own is a challenge, but them getting enough experience is the challenge for them to want to stay out in the regions and feel like they are a part of the action. You have raised that enough, I think, for us to get on the record that we need to address that challenge or we are not going to be able to stimulate them and keep them inspired and we are not going to be able to support the regions well enough, so thank you for that.

You also talked about the fact that you are going to grow the amount you turn out in the west and the east from 25 to 40. Is that because you have done the work to see the needs to meet the demands? What has driven that figure from 25 to 40 as your goal?

Ms JONES — How can I say it? It is a very pedantic reason. It was a number put out by the university to say that in order to run the program we need to have minimum numbers of students. If we do not get the minimum numbers of students, they will close the program, and that would be a disaster for regional areas.

Ms BRITNELL — It would. Okay, and the other one: we have heard a lot about the regions having challenges with the BMI challenge and obesity, diabetes as a result. Are they the sorts of areas that you think regional research could be done on?

Ms JONES — Absolutely, all that sort of stuff, particularly around keeping women in their communities where possible, because it is incredibly disruptive if women have to leave their community to have their baby. Sometimes that is unavoidable, but we can look at ways to manage that, to perhaps reduce the risk factors, starting really early to try to reduce the risk factors. Instead of getting to the end and going, 'My God, this woman can't possibly stay in Bairnsdale; she's going to have to go to Sale or Traralgon or something', perhaps addressing that much earlier on.

The CHAIR — Jan, thanks so much for your time today. You have given us plenty to go on with, I feel. Thanks so much.

Ms JONES — Thank you so much for inviting FedUni to present.

The CHAIR — No worries. We appreciate your time. Thank you so much.

Ms JONES — No worries at all. Thank you.

Witness withdrew.