National Review of Nursing Education 2002

Our Duty of Care

Chair, Patricia Heath
Dear Ministers

It is with pleasure that I present the final report of the National Review of Nursing Education: Our duty of care. The National Review of Nursing Education was announced on 28 April 2001 by the then Ministers for Education, Training and Youth Affairs (Dr David Kemp), and Health and Aged Care (Dr Michael Wooldridge).

Due to the complexity of issues impacting on nursing and the responsibilities of Commonwealth, State and Territory governments in various aspects of both the nursing education and the nursing workforce, the Review Panel made the decision to consider the broad range of issues facing nursing from a national perspective. During its deliberations the Review Panel at all times remained cognisant of the terms of reference under which the Review was called.

The National Review of Nursing Education was aided immensely by the contribution and generosity of so many individuals, organisations, institutions and government departments. The information gathering and consultation process of the Review during the period June 2001 to March 2002 involved the receipt of 159 submissions to the Review, over 150 written responses to the Review's Discussion Paper (released in December 2001), in excess of 100 meetings with State and Territory government departments, nursing regulatory bodies, representative organisations, hospitals and universities, and 15 open public consultation meetings. The Panel greatly valued the overwhelmingly positive support it received in its visits across Australia, and the quality of the information that so many departments and organisations were willing to share. It became apparent early in the consultation process that the nursing community in Australia was monitoring the progress of this Review keenly, and was prepared to work collaboratively with all levels of government, educators and employers, to improve nursing in this country.

A body of research was commissioned for the National Review of Nursing Education, and I would like to express my appreciation to all those involved for working with us to meet our tight timeframe, and for their attendance at the Review's Research Forum in October 2001. This allowed the Review Panel to further explore issues that were arising in terms of the research outcomes in the context of the Review's terms of reference. I would also like to extend my gratitude to the members of the Reference Group for the National Review of Nursing Education who provided invaluable comment and advice.
The Review Panel comprised of Ms Jenny Duncan, Ms Ella Lowe, Ms Susan Macri, Mr John Ramsay, Professor Christopher Selby Smith and Professor Robin Watts. The knowledge and expertise of my colleagues on the Panel across the breadth of issues facing the Review was crucial to our enquiries. I wish to thank them all for their professionalism and for their willingness to give so much of their time to this Review.

The Secretariat team in Canberra, in its role of administering, coordinating and supporting the many aspects of the Review, was also essential to the Review. The secretariat was led by Dr Elizabeth McDonald and comprised Ms Melanie Coates, Ms Dianne McKenna Hantas, Ms Yolande Peuker, Ms Shane Samuelson and Ms Natasha Wade. I particularly wish to acknowledge the enormous effort Elizabeth McDonald has invested in this Review over the past 16 months, and to extend my thanks for supporting me so ably during that time, and for coordinating the writing of this report.

I believe that this report presents an achievable set of recommendations which will take nursing forward in Australia. Implementation of these recommendations is going to require collaboration, true leadership and commitment by all levels of government, all educators, all employers.

I would like to thank the present Ministers for their support, and the original Ministers for appointing me to chair what I consider to be the most interesting and challenging review of my 37 year career in the health and education fields. I commend this report to you for your favourable consideration.

Patricia Heath
Chairman

August 2002
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Introduction

On 30 April 2001, the former Commonwealth Ministers for Education, Training and Youth Affairs and for Health and Aged Care jointly announced the National Review of Nursing Education. State and Territory health ministers were consulted on the terms of reference before the announcement of the Review.

The result of these consultations is that the terms of reference encompass not only initial registered nurse preparation, an area funded by the Commonwealth, but also enrolled nurse education, which is largely funded by the States and Territories. The Review also encompasses education for specialisation, continuing education and the relationship of nursing with other groups in the health workforce. The term ‘health workforce’ is taken to include sectors such as aged and community care where nurses play an essential role.

The group impacting most directly on the work of nurses (particularly in the community and aged care sectors) is the unregulated carer group. The report pays particular attention to this group because of the impact it has on both the work of nurses and the safety of clients and patients.

Purpose of the Review

This Review was established by the Commonwealth Government to examine the future nursing educational needs of the health, community and aged care system and to advise on appropriate education policy and funding frameworks. Its role is not to define ‘nursing’, nor to enter into debates about the discipline or profession of nursing. It is for nurses themselves to resolve their concepts of professionalism and to develop their discipline.

The Review addresses nursing education in relation to patient and client health outcomes. However, to produce useful advice to government, the Review must understand:

- the culture of nursing and the ways that culture is supporting or obstructing the work of nurses and carers
- the role of nurses in the health, community and aged care systems and the ways this role is changing
- the relationship of nurses with the other providers of health care
- the policy and funding frameworks that affect the education systems and health, community and aged care systems within which nurses are educated and work.

Terms of reference

The terms of reference for the National Review of Nursing Education include a contextual statement that links the current arrangements and the changes in labour markets as a key to the issues underpinning the Review. The terms of reference are as follows.

To examine:

- the effectiveness of current arrangements for the education and training of nurses encompassing enrolled, registered and specialist nurses
- factors in the labour market that affect the employment of nurses and the choice of nursing as an occupation
• the key factors governing the demand for, and supply of nursing education and training.

To make recommendations on:
• models of nurse education and training to meet the emerging labour force, including practical training, processes for articulation between different levels of competency and professional expertise and re-entry into the workforce
• the types of skills and knowledge required to meet the changing needs of the labour force involved in nursing
• mechanisms for both attracting new recruits to nursing including those from different age groups (both male and female) and encouraging the commitment to lifelong learning of those already engaged in nursing.

To consider the following wider issues from the perspective of both the health industry and education:
• the changing context of nursing and health requirements and the levers influencing these changes
• the links between nursing, medicine and other groups in the health workforce (including those with no health qualifications) in the provision of health services.

To have regard to:
• regional needs and circumstances
• financing arrangements
• the work of current research projects and reviews such as the New Zealand review of nursing education, the Australian Health Workforce Advisory Committee nursing workforce review, and the British review of funding for nursing.

The terms of reference, with the supporting statements, are at Appendix A.
Review Panel
Mrs Patricia Heath AM BEM RCNA (HON) (Chairman)
Ms Jenny Duncan
Ms Ella Lowe
Ms Susan Macri
Mr John Ramsay
Professor Christopher Selby Smith
Professor Robin Watts

Reference Group
Listed below are the organisations invited by the Ministers to join the Reference Group for the Review. The list also shows the representative of the organisation who attended the meeting with us in April 2002 to provide advice on the developing recommendations.
• Australian Council of Deans of Nursing
  Professor Judith Clare
• Association of Australian Rural Nurses
  Ms Jenny Critchley
• Council of Remote Area Nurses of Australia Inc
  Ms Melanie Van Haren
• Congress of Aboriginal and Torres Strait Islander Nurses
  Ms Sally Goold
• Royal College of Nursing Australia
  Ms Rosemary Bryant
• Australian Health Ministers’ Advisory Council
  Ms Judith Meppem, Ms Karen Lesley Roach
• Australian Private Hospitals Association
  Ms Cathy Miller
• TAFE Directors Australia
  Ms Marie Persson
• Youth Round Table
• Australian Vice Chancellors Committee
  Professor Lesley Barclay
• Group of Eight
  Professor Sue Armitage
• Australian Nursing Council Incorporated
  Ms Marilyn Gendek
• Australian Local Government Association
  Councillor Felicity Lewis
• Catholic Health Australia
  Ms Brigid Tracey
• Aged and Community Services Australia
  Ms Pat Sparrow
The Review process

Following the announcement of the Review, the Chairman, Mrs Heath, attended the International Nursing Council Conference in Copenhagen and visited England and Ireland to establish what was happening internationally in nursing and nursing education.

In August and September 2001, we held meetings in each State and Territory with a wide range of bodies (see Appendix B for details). The organisations and sites visited included:

- State and Territory education departments
- State and Territory health departments
- State and Territory nursing boards
- State and Territory nursing unions
- TAFE institutes and universities
- open public consultations
- hospitals
- the Australian Council of Deans of Nursing
- the Australian Nursing Council Incorporated
- the Australian Nursing Federation
- the Royal College of Nursing, Australia
- the NSW College of Nursing.

Submissions

To give as wide an opportunity as possible for interested parties to influence the outcomes of the Review, we sought advice through submissions, of which 159 were received. The table 'Distribution of submissions by State Territory and organisation' shows the distribution of submissions received by State or Territory and type of organisation. The list of organisations and individuals who sent submissions is at Appendix C.
Distribution of submissions by State/Territory and organisation

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Research and literature reviews

In addition, we commissioned a wide range of research and six literature reviews. In October 2001, we held a research forum to explore the implications of the findings of the research with the researchers and a number of other experts. Reference to these studies in this report is to the website address giving the date first published. Consequently, page numbers for quotations are not included. The research reports have also been published collectively in hard copy to accompany this report (see Appendices D and E for details).

Discussion Paper

The release of the National Review of Nursing Education Discussion Paper in late December 2001 provided stakeholders with another opportunity to advise on issues of particular interest. The Discussion Paper was published, along with the research, on the Review website at <www.dest.gov.au/highered/programmes/nursing> and was also distributed widely. The Discussion Paper drew together all the views and sources of information and sought responses to a list of questions. We received over 150 responses to the Discussion Paper and found the expert advice, opinions and suggestions were invaluable in our deliberations. The table ‘Distribution of responses Discussion Paper by State/Territory and type of group’ shows the types of groups who responded and the State and Territory distribution. A synthesis of the themes from the submissions and responses to the Discussion Paper is at Attachment A.

Distribution of responses to Discussion Paper by State/Territory and type of group

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In March 2002, we undertook another round of meetings with key stakeholder organisations before developing the recommendations of the Review. We then met the members of the Reference Group in April and representatives from the Commonwealth Departments of Education, Science and Training and Health and Ageing to test the broad directions of system level recommendations.

Inquiry into Nursing
The Senate Community Affairs Reference Committee Inquiry into Nursing occurred over the same period as the Review, reporting in June 2002. We have taken the information and findings of the Senate Committee Inquiry into account in writing this report. The terms of reference for the Inquiry into Nursing, along with our comments on the recommendations, are at Attachment B. The findings of the Inquiry are available on the Senate Committee’s website at <www.aph.gov.au/senate/committee/clac_ctte/nursing/index.htm>.

Review of higher education
In April 2002 the Minister for Education, Science and Training announced a review of higher education with the release of an overview paper, Higher education at the crossroads.

In the preface to the paper, the Minister proposes that there should be consideration and debate of ‘the policy options that lie before us in relation to reform to the way we administer, fund and support Australian universities’ (Nelson 2002, p. v). The outcomes of this review may have implications for nursing education and training in the higher education sector.

Structure of the report
The report contains the summary and recommendations from the Review followed by the supporting argument for the recommendations. Both are underpinned by the extensive information found in the National Review of Nursing Education Discussion Paper, which is available in hard copy and on the Review website at <www.dest.gov.au/highered/programmes/nursing>, along with the research commissioned for the Review. A list of the commissioned research is at Appendix E.

In developing the recommendations, we sought to improve structures and process at a level that will stimulate innovation and improvement throughout the system. While some issues and groups may appear less obvious in this approach, we have not overlooked them. We have treated the needs of particular groups such as Indigenous Australians, rural and remote populations and recent immigrants within an integrated framework, but we have also specifically identified these groups in our deliberations. This is also true of particular service areas such as mental health and aged care.

Rationale for the report
The following seven themes provide the understandings and positions that form the basis of the report and its recommendations.
Health care is a national issue

The health care of Australians is a national issue in which all levels of government have roles and responsibilities, as do different government portfolios and the non-government sectors. As a nation, we need to overcome current barriers and disconnections between the Commonwealth and the States and Territories, between the larger and the smaller States and Territories, between metropolitan and non-metropolitan areas (regional, rural or isolated) and between particular portfolios. Nurses are key players in the health, community and aged care sectors, and we believe that governments must adequately invest in both their education and work.

Healthcare provision must be effective and efficient

An effective and efficient healthcare service is essential because this is an area of enormous public investment in a climate of increasing demand on costly services. The cost of health care is rising, the population is ageing, consumer expectations of and demands on the health system are increasing, and the potential to intervene through new technologies is expanding. These changes mean that an important issue in the emerging healthcare system will be equitable access to treatment and care. In turn, the costs of litigation create serious questions for an efficient and effective healthcare service as consumers develop different attitudes to the relationship between themselves and service providers. Under these circumstances, the contribution of nursing to the efficiency and effectiveness of the system is important.

Nursing is a profession

Nurses make up the largest professional group in the healthcare system, and have a unique, continuously developing role. Work organisation and management processes need to recognise their high level of education. The regulatory and legislative framework for nursing should recognise nurses’ education and professional codes. In addition, since nurses work alongside a number of other health professionals and care workers who provide varying levels of care or specific services contributing to the wellbeing of their clients, the professional role of nurses in the team should be acknowledged. Nurses as professionals need appropriate delegations to work safely with workers who form part of the nursing workforce.

Future development should build on current expertise and promote continuous improvement, planning and quality

Nursing expertise in Australia is high. In developing the recommendations, we have recognised the current systems and successes and have used them as the underpinning of the proposed systems of planning and development for the future. We believe that such planning and monitoring should occur at all levels of education and service provision. These systems need to include the strengthening of workforce planning and monitoring, as well as promoting efficient and effective delivery of nursing care. To this end, we support processes that are flexible and that promote continual evaluation and improvement.

Nursing is a practice discipline

The education of nurses must be closely linked to practice, both in planning and delivery. Maintaining links between practice and education is costly. However, educators and practitioners need to constantly update their competencies as technologies and scientific and social understandings continue to develop rapidly. Educators and clinicians need to be
able to remain current in their practice—the former so that they can help their students gain an understanding of the latest treatments and new technologies, and the latter to ensure safe and competent service delivery. Students must learn to integrate both the practice and the theoretical knowledge. This can occur only when they have the opportunity to ‘learn’ in a practice environment as well as an academic environment.

Nursing should be inclusive
The nursing profession is not representative of the Australian population. Nursing needs to move from a largely mono-cultural group of predominantly women to one that reflects current Australian society. In revising the profession, nursing will need to encourage recruitment through a wide range of pathways, support new professionals of whatever age and welcome those who move between different career options.

Partnerships are essential for quality practice and education
We believe that a partnership approach is the only way to overcome current difficulties and to set a productive direction for the future. At the national level there will be a need for partnerships between governments and portfolios to address nursing issues. There will also need to be a range of other partnerships that manage areas of joint responsibility, particularly those related to the formation of the new professional.

On the basis of these propositions, we present a report and recommendations that seek to promote collaborative approaches to the resolution of problems, to use current expertise and systems where they are available, and to facilitate future developments.

Nursing education in Australia
There are many ways to tell the story of nursing education. One way would be to give a recent history and overview, as if nursing education sat in a bounded space.

Another way is to examine what has happened to nursing work across Australia because of changes in the way health, community and aged care services are delivered and the way education and training are currently structured, and to situate nursing education within that story. This approach is the most productive because of the number of stakeholders and contributors to the preparation of nurses and the number of people who support the work of nurses.

While the story today is one of challenge, it is also one of achievement and innovation. The Australian community regards nurses highly due to the eminent service they provide. The nursing profession has developed a cohesive Australian standards framework in the Australian Nursing Council Incorporated (ANCI) competencies for registered and enrolled nurses. This framework defines what the profession expects of its members and is an enormous achievement when the many complex arrangements that mark a federated system of government are considered. These achievements are testament to the leadership provided by individual nurses and nursing groups such as the ANCI, the Australian Nursing Federation, the Royal College of Nursing, Australia, the NSW College of Nursing, the Australian Council of Deans of Nursing, and the many other professional nursing bodies.

Much has happened at all levels of education across the last decade. Three changes that have had significant consequences for nursing, since they affect the structure of the education and training system and the type of education nurses receive, are:
• the development and modification of a national training framework for vocational education and training (VET) which incorporates the later years of schooling
• the finalisation of Dawkin's restructure of higher education from a two-tiered system, consisting of colleges of advanced education and universities, to a unified single tier system of universities
• the completion of the transfer of registered nursing preparation into the higher education system (specialist nursing education has since drifted into the higher education sector as universities started to offer a variety of postgraduate nursing programs).

The changes in the VET sector and the transfer of registered nurse preparation into the higher education sector are discussed later in this report. The Dawkin's restructure had implications for nursing as many nursing courses were already established in colleges of advanced education (CAEs) before the agreement to shift registered nurse preparation to the higher education sector in 1984. Under the restructure, CAEs became part of a rationalised system, which consisted of 35 universities by 1991. As this report goes to print, another review of higher education is occurring and it too is examining the structure of higher education.

Some of the most exciting trends that have evolved from the changes in the VET sector and the preparation of registered nurses are in the area of partnerships. Three-way partnerships between a health service, TAFE and university are examples of best practice. Schools have also been involved in arrangements that provide training and exposure to nursing work in aged and healthcare facilities. The growing number of joint chairs and other appointments between universities and the health sector are other examples. Moreover, developments in models of clinical education demonstrate strong relationships between universities and health organisations.

The expertise in nursing education and research capacity at universities is expanding as is evident in the international consultancies, the Australian research contracts and the increasing number of international students. In addition, the number of clinical chairs suggests that the strength of clinical research is also growing.

While the strength of the nursing profession in Australia is demonstrated by these considerable achievements, a group of workers who contribute to nursing work, particularly in the aged and community care sectors, has received little attention. These are the workers known as assistants in nursing, personal care assistants or by other titles. They also face challenges arising from the environments in which they work and from the increasing demand for caring work as the population ages and, with it, the number of people who need assistance with daily living increases.

The following chapters document in more detail the story of Australian nursing education, its current challenges and our recommendations.
Summary

Nurses are a vital part of the health, aged and community care systems in Australia. The work they do not only supports those who have particular care needs but also underpins much of the social structure in communities and care facilities. Therefore there is a wide range of stakeholders with an interest in ensuring that nursing functions well in the many settings that require nursing knowledge and expertise. These stakeholders range from hospitals to remote communities, from prisons to the Australian defence forces, from homes to schools.

Australian nurses should be proud of the contribution they have made, often with limited acknowledgment other than the community's trust. Nurses have developed as a profession, establishing a number of important bodies to draw together different aspects of nursing on a national basis. Other achievements include the important developments in nursing education. The preparation of enrolled nurses has become established in the vocational education and training system and that of registered nurses in the higher education system. There is also progress towards the development of a strong evidence base for nursing through research training and developments such as clinical chairs—though there is much work yet to be done in consolidating that evidence base and applying it in clinical settings.

Nurses have received attention not only in Australia but also in many other countries because of growing shortages and increasing demands for care as populations age and community expectations of care change. There is a remarkable similarity in the findings of our report and recent reports from other countries and from within Australia. We reflect the same issues and offer many similar solutions.

During the Review, we used many information sources and people to try to understand nursing, its practice and the drivers that influence change. Combined with increased demands for nursing work, the rapid growth in knowledge and technology has changed and continues to change the nature of that work, presenting ongoing challenges for nursing education and practice. These rapid developments require solutions that set standards and build the capacity to address and plan for change—not prescriptive models of education and training that will be outdated before they are implemented. Rapidly evolving technical knowledge environments also make heavy demands on organisations to develop and extend their staff through ongoing education and training. While not all care environments fit this description, many nurses work in areas demanding high levels of technical competency. Consequently, the initial preparation of nurses needs to set the foundation for ongoing learning.

National partnerships

Despite the progress and the important role nurses have had in caring for the Australian people—whether in the cities or in rural and remote settings, where they often form the front-line of health care—there are a number of barriers to nursing development. Many of these flow from the fragmentation brought about by different policy and funding responsibilities. These barriers need to be removed and replaced with a more coordinated national approach.
Proposed National Nursing Council of Australia

To provide nursing with a means of responding to these challenges and at the same time promote the ongoing development of nursing, we have taken a strategic approach to our recommendations. This approach supports flexibility and responsiveness and builds capacity to enable nursing to be best placed to respond to the changing healthcare environment.

As part of our longer term vision, we propose a national nursing council, the National Nursing Council of Australia, which would provide a national focus that brings together all stakeholders to overview the full range of issues related to nursing. We envisage this body drawing on the considerable existing expertise at a national level and providing a focus for nursing leadership, while also developing nursing leadership and management at all levels. A national body offers a new way of promoting nursing both at home and in the international arena and a resource for government in planning health, aged and community care provision for the future.

We identify the potential contribution of the National Nursing Council of Australia as:

- providing national leadership on nursing policy, education, training and practice
- facilitating the work and activities of other nursing bodies
- promoting and facilitating consistency in nursing education, training and practice to improve the quality and safety of nursing care throughout Australia
- developing and promoting nursing leadership at all levels
- building capacity in the nursing profession and workforce.

Recommendation framework

In addressing our other recommendations, we used a broad framework aimed at responding to current challenges, consolidating and building on existing achievements and providing the support and infrastructure for the future development of nursing. Since nursing is a practice discipline, nursing education and nursing practice are interdependent. Therefore, although the focus of our review is education, this cannot be examined in isolation from the current situation for nursing practice.

While conducting the Review, we faced the complex situation of nurse shortages. Under these conditions it is difficult to provide new graduates with the support they need and are entitled to expect as new entrants to a profession, and to find quality clinical placements for all students. At the same time, there is growing pressure to increase the number of nursing students to meet both the current demands and those of the near future when a high proportion of the nursing workforce will retire. These different pressures show how important it is to find solutions that bring together all the parties responsible for the different elements of the solution.

Our recommendations support one or more of the elements of three strategies designed to draw together the parties responsible and the issues that must be addressed. These strategies are:

- building a sustainable nursing workforce
- maximising health outcomes through quality education
- capacity building.

The strategies themselves are interdependent, so the recommendations in some cases form part of the platform for more than one strategy.
Strategy 1: Building a sustainable nursing workforce

In the context of our report and recommendations we define the nursing workforce, in the broadest sense, to encompass:

- registered nurses (general and specialist), midwives and mental health nurses
- enrolled nurses
- nurse practitioners
- nurse managers
- nurse educators (working in hospitals, universities and the vocational education and training sector)
- trained care assistants.

We use the name 'trained care assistants' to represent the group of workers involved in care work who are known by a range of titles, including assistants in nursing, personal care assistants, and aged and disabled person carers. While we argue that this group of workers needs both a common name and a minimum level of competency, we do not advocate a particular name. Rather, we have called the group 'trained care assistants' to enable us to discuss them in this report.

Elements of a sustainable workforce

Augmentation and retention of the current nursing workforce

There needs to be a major investment in retention of the existing workforce, recruitment of nurses not currently employed in nursing, and recruitment from overseas. All the evidence suggests that it will be impossible to meet the demands for nursing services by focusing on new graduates alone. The most crucial factor in ensuring an adequate supply of nurses for the future will be to retain as many of those nurses currently employed as possible, particularly those in the earlier years of their careers.

Transition programs

Transition programs provide the initial sustained exposure to the daily management and application of the theory learnt during the undergraduate course for the new registered nurse, or vocational education and training for the new enrolled nurse. Good transition programs encourage new nurses to remain in the workforce. These programs are an essential part of any strategy to maximise the community's investment in the education and training of nurses.

Skill mix and work organisation

Appropriate skill mix and investigations about how work could be better organised are necessary. The evidence points to the unsustainability of current arrangements. This is not to suggest the substitution of professional nurses where they are using their expertise to achieve the best outcomes for patients/clients. Rather, there should be an examination of the ways in which the different skills of different groups who form the team of people doing nursing or care work can be best organised to ensure optimum outcomes for patients/clients.

Supply of nursing staff

Supply of all levels of nurse and trained care assistants is important in building a sustainable workforce. A focus on only registered nurses will not result in the appropriate use of nurses in different settings, nor encourage the strengthening of career pathways from...
trained care assistants to the range of nursing career options, including nurse practitioner. Supply needs to be increased, particularly of enrolled and registered nurses.

Sound data and a reliable evidence base
The availability of sound data and a valid, reliable evidence base provides the platform for decisions on supply, skill mix, work organisation and policy. Currently, the availability of quality data and evidence in relation to the nursing workforce and nursing work is very limited.

Strategy 2: Maximising health outcomes through quality education

Training of care assistants
The appropriate level of education and training of care assistants is essential to the safety of the patient/client as well as their comfort. While there is growing recognition of the need for appropriately trained care assistants, Australia has yet to ensure that all those involved in care work have an appropriate level of competency to secure safe practice. Moreover, as a country, we need to develop an understanding of the nature and extent of their contribution.

Clinical education
Clinical education is an essential component of education and training for a practice profession and is required to ensure the quality of preparation for new professionals and specialist nurses. Providing the appropriate funding and building collaborative relationships are key to developing confident and competent new professionals and specialist nurses for the various settings of care.

National education standards
Defining national standards for nurse education at all levels and for trained care assistants, combined with appropriate quality assurance processes, is an important part of the process of ensuring quality education of the nursing workforce. The underpinning of quality education and training is fundamental to the development of educational pathways that facilitate transition between careers. In a world of rapid change, efficient transition processes are important to both the individual and to the health, aged and community care systems because they broaden the group of people who can be educated and trained to carry out the work required.

Flexible education programs
The capacity to develop and continue to evolve flexible and responsive education and training programs in the constantly changing environment in which health, community and aged care function is essential. With its broad professional base and range of competencies, nursing is in a unique position to respond to those changes. To achieve this responsiveness, nursing education providers need to be current in their understanding of practice, be attuned to changes and be innovative in their education processes for all levels of nurses.

Strategy 3: Capacity building

Nursing research
Nursing research and the development of nursing researchers provide the underpinning infrastructure for good decisions by policy makers and for improvements in clinical nursing
practice and education. The means to more efficient, effective health outcomes from nursing work and to quality education of nurses is building nursing research capacity and developing the ability to apply the findings of that research.

Development of organisational knowledge and skills
Learning organisations need to develop the capacity to support and develop the knowledge and skills within the organisation. Since the transfer of registered nursing education from hospitals, much of the supporting infrastructure for clinical nursing development has been lost. Clinical development of nurses can only be done well where the expertise is located—and that is usually with the nurse clinician. Rebuilding and further developing clinical education systems in hospitals, and the community and aged care sectors will provide the capacity for care services to build best practice and evaluation of practice into their systems.

Linking strategies and recommendations
Given the number of players with different responsibilities for diverse but intertwined elements of nursing, Australia will need to develop collaborative partnerships at all levels to make progress in many of the problem areas faced by nursing today, and to plan and respond to future challenges. At present there is little opportunity for this to occur in a way that interfaces all the different interests.

We believe it is in the national interest to promote arrangements that bring together the Commonwealth, State and Territory health and education interests, nursing bodies, and the range of service providers, including government and non-government, that represent the different contexts in which nurses work. Promoting these partnerships is the vision we share in presenting our report and recommendations. The figure 'Overview of strategies and recommendations' shows how the strategies and recommendations in this report are linked.
Figure 1: Overview of strategies and recommendations

- National Nursing Council
- Image of nursing
- Scope of practice
- Agreed practice standards
- National perspective
- Capacity building
  - Agreed educational standards
  - Nurses as trainers and assessors
  - Care assistants
  - Clinical education
  - Innovation and responsiveness
  - Standards
- Supply linked to demand
- Maximising educational pathways
- Multi-professional teams
- Lifelong learning
- Access and equity
- Supply linked to demand
- Maximising educational pathways
- Supply of nursing workers
- Transition
- Skill mix and work organisation
- Planning
- Agreement of practice standards
- Sustainable workforce
- Augmentation and retention
- Transition
- Skill mix and work organisation
- Planning
- Quality education
  - Nurses as trainers and assessors
  - Care assistants
  - Clinical education
  - Innovation and responsiveness
  - Standards
  - Supply linked to demand
  - Maximising educational pathways
  - Multi-professional teams
  - Lifelong learning
  - Access and equity
  - Supply linked to demand
  - Maximising educational pathways
  - Supply of nursing workers
  - Transition
  - Skill mix and work organisation
  - Planning
  - Agreement of practice standards
- National perspective
Overview of strategies and recommendations

Recommendations

This Review was commissioned by two Commonwealth Ministers and supported by the State and Territory Health Ministers. However, it must be recognised that many other stakeholders have an interest in the outcomes of the Review and are also essential to the success of the Review. These include other portfolios such as Defence, Veterans’ Affairs, Employment and Immigration, as well as nursing and education organisations. Other players essential to the outcomes are the employers.

Often the contribution of individual nurses is overlooked in reviews that focus on issues of system change and funding implications. We are acutely aware of the contribution of individual nurses to the health care of the Australian people. The energy, support, commitment and creativity of individual nurses is the only way the implementation of new arrangements and processes will make a difference and enable the significant successes already achieved to be consolidated.

These recommendations have been based on the fundamental principle that, in order to provide a universal healthcare system that provides safe and quality outcomes, an adequate investment in nursing education and training is essential. This investment is primarily a public responsibility rather than a matter for the private market.

The following seven themes provide the understandings and positions that form the basis of the report and its recommendations:

• Health care is a national issue.
• Healthcare provision must be effective and efficient.
• Nursing is a profession.
• Future development should build on current expertise and promote continuous improvement, planning and quality.
• Nursing is a practice discipline.
• Nursing should be inclusive.
• Partnerships are essential for quality practice and education.

Recommendation 1—Implementation taskforce

Commonwealth, State and Territory health and education and training ministers should establish a national implementation taskforce to action, monitor and report on the progress of implementation of the recommendations.

Proposed responsibility: Commonwealth, State and Territory health and education and training departments

(Relevant discussion Section 5.1.1)
Recommendation 2 — Establish a National Nursing Council of Australia

Key to the development of Australian nursing is nursing leadership and national coordination. To achieve these outcomes:

a) An independent National Nursing Council of Australia (NNCA) should be established.

b) The body should be established, for five years in the first instance, to:
   i. provide national leadership in relation to nursing policies, education, training and practice
   ii. facilitate the work and activities of other nursing bodies
   iii. promote and facilitate consistency in nursing education, training and practice to improve the quality and safety of nursing care throughout Australia
   iv. develop and promote nursing leadership at all levels
   v. build capacity in the nursing profession and workforce.

c) The NNCA and its secretariat should be funded by Commonwealth, State and Territory governments with in-kind contributions from nursing organisations.

d) Membership should comprise nurse regulatory authorities, public and private sector nursing, nursing education at all levels, professional and industrial organisations, and representatives of Commonwealth, State and Territory health and education policy and funding organisations.

e) The Chair of the NNCA should be a nurse appointed by the Commonwealth, State and Territory health and education and training ministers.

f) It is not intended that the NNCA undertake work already effectively undertaken elsewhere and it is envisaged that, to pursue health, education and training outcomes, the NNCA should create appropriate links with other national and international bodies.

Proposed responsibility: Commonwealth, State and Territory health and education and training ministers, with details to be developed by the implementation taskforce

(Relevant discussion Section 5.2.1)

Recommendation 3 — Nursing education and workforce forums

State and Territory governments should establish nursing education and workforce forums to:

a) facilitate collaboration between the education sectors and the health and community and aged care sectors, including both the public and private sectors

b) address local and regional nursing education and workforce issues

c) assist with the implementation of the recommendations of this Review.

Proposed responsibility: State and Territory health and education and training departments

(Relevant discussion Section 5.2.3)
Recommendation 4 — Nationally consistent scope of practice
To promote a professional scope of practice for nurses and greater consistency across Australia:

a) a nationally consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses

b) to facilitate this development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required.

Proposed responsibility: Implementation taskforce with the NNCA
(Relevant discussion Section 5.3.3)

Recommendation 5 — National standards for nurse practitioners
To promote a consistent national approach, the Australian Nursing Council Incorporated (ANCI) should be commissioned to establish national standards for nurse practitioners.

Proposed responsibility: Commonwealth, State and Territory health ministers
(Relevant discussion Section 5.3.4)

Recommendation 6 — National ANCI principles to underpin nursing legislation and regulation
To ensure a more nationally consistent approach to nursing, State and Territory nursing legislation and regulations should be underpinned by nationally agreed principles. These principles should include requirements for:

a) assessment against the ANCI competencies for initial registration of registered nurses and enrolled nurses

b) audited self-reporting for continuing registration of registered nurses and enrolled nurses using indicators that demonstrate currency of competence including ongoing education.

Proposed responsibility: ANCI in consultation with the NNCA
(Relevant discussion Section 5.3.5)
Recommendation 7 — Care workers not covered by regulation
To ensure quality and safety in the health, aged and community care sectors, all workers without relevant recognised training who are employed to provide direct care should have:
   a) a common national nomenclature
   b) a minimum competency level of Certificate III from the appropriate Community Services or Health Training Package
   c) an appropriate suitability check.
As a matter of urgency, the Commonwealth, States and Territories should establish or utilise an appropriate system to ensure that compliance in relation to the minimum qualification and suitability checks for care assistants is achieved by 2008.
Proposed responsibility: Implementation taskforce
(Relevant discussion Section 5.3.6)

Recommendation 8 — Research and research training for nursing
To build capacity in a vital discipline that has only been in the university sector for a relatively short period:
   a) immediate steps should be taken to ensure that the current level of postgraduate research scholarships and research training places for nurses are at least maintained, with the longer term target of doubling Research Training Scheme (RTS) commencement load by 2008.
Proposed responsibility: Implementation Taskforce and Department of Education, Science and Training
   b) a dedicated pool of funding from new or existing sources should be made available over the next five years to provide research grant money and for cooperative research centres for nursing.
      i. particular priority should be given to building longer term capacity and integration of research findings into practice
      ii. priority areas might include evidence-based practice, aged care, work organisation, mental health nursing, and nursing in rural and remote areas.
Proposed responsibility: Implementation taskforce
(Relevant discussion Section 5.6)
Recommendation 9—The image of nursing
To develop and improve the image of nursing:
  a) the value, contribution and benefits of a nursing career should be promoted
  b) expert advice should be sought to develop a national marketing profile (brand) for nursing
     i. the profile should help generate a broader base of recruitment to nursing which reflects the diversity of the Australian population
     ii. the profile should be used by States and Territories, the universities, the vocational education and training sector, career counsellors and others concerned with recruitment and retention.

Proposed responsibility: NNCA with advice to governments and other employers
(Relevant discussion Section 6.1.1)

Recommendation 10—Information on nursing
To provide coordinated and ready access to information on nursing to the public and other stakeholders, the NNCA should:
  a) maintain an information base of recruitment and re-entry programs, assessments of their effectiveness and advice on best practice
  b) develop a web-based portal for Australian nursing.

Proposed responsibility: The NNCA
(Relevant discussion Section 6.1.2)

Recommendation 11—Government and employer information on nursing
To ensure that nursing is portrayed as a profession in government and employer information, all levels of government and other employers of nurses should:
  a) review their recruitment and promotion activities to ensure they reflect the professional status of nursing and the valuable social contribution made by nursing through its diverse roles and practice
  b) review their classification of ‘nursing’ to ensure it is consistent with the Australian Standard Classification of Occupations (ASCO) classification, in order to reflect the professional status of nursing.

Proposed responsibility: Commonwealth, State and Territory governments, and other employers of nurses
(Relevant discussion Section 6.1.2)
Recommendation 12—Maximising education pathways
To promote career transitions and opportunities for development in the education and training of care assistants, health workers, enrolled nurses, registered nurses, midwives, nurse practitioners, nurse educators and nurse managers, education providers should seek ways to:

a) maximise the potential for Recognition of Prior Learning (RPL) and Recognition of Current Competency (RCC) in enrolment processes
b) in consultation with local Indigenous communities, improve articulation pathways for Aboriginal and Torres Strait Islander peoples.

Proposed responsibility: Education providers
(Relevant discussion Section 6.3.1)

Recommendation 13—Student nurse employment
With a view to achieving national consistency, the NNCA should examine the financial benefits and experience that might accrue to student nurses (and the implications for the workplace) from their employment in the health workforce at their level of competence (but not as part of the requirements of their educational program).

Proposed responsibility: The NNCA
(Relevant discussion Section 6.3.6)

Recommendation 14—Standards for transition programs
To ensure consistency and quality in the development and delivery of transition programs:

a) a national framework should be developed for transition programs to provide guidelines and standards for institutions
b) State and Territory nursing registration boards should accredit transition programs
c) employing institutions should be responsible for meeting the standards.

Proposed responsibility: ANCI in consultation with the NNCA, State and Territory nursing registration boards and employing institutions
(Relevant discussion Section 6.4.1)
Recommendation 15 — Continuing clinical development of nurses
To promote the ongoing development of nurses’ clinical competencies in the workplace, Commonwealth, State and Territory national health funding arrangements should dedicate funds to the provision of:

a) clinical development support in healthcare settings for nurses at all levels and the necessary infrastructure for education and training in the healthcare system
b) transition to practice programs for new nurses, both enrolled and registered, and for nurses returning to the workplace
c) support for these developments, including preceptorship and mentoring.

**Proposed responsibility:** Commonwealth, State and Territory health ministers

(Relevant discussion Section 6.4.2)

Recommendation 16 — Continuing clinical development of nurses: aged care
To promote ongoing development of nurses’ clinical competencies in their workplaces, Commonwealth, State and Territory aged care responsibilities and funding arrangements should:

a) endorse and ensure continuing support for the standards and guidelines for residential aged care services in relation to the clinical education of nursing staff as outlined in the aged care accreditation standards
b) endorse and encourage the provision of transition programs for new graduate nurses, both enrolled and registered, in aged care organisations.

**Proposed responsibility:** Commonwealth Minister for Ageing

(Relevant discussion Section 6.4.2)

Recommendation 17 — Transition to workforce: funding
The Commonwealth, States and Territories should establish a system to allocate dedicated funds to (public and private) health and community care institutions to assist registered nurses and enrolled nurses in making the transition into employment, including the transition into employment of those nurses who have completed a re-entry program.

a) Allocations should attach to the individual employee or registrant (and should be made on their behalf) to institutions whose programs have been accredited for transition
b) Transition programs should be encouraged in areas such as mental health, aged care, community nursing, and rural health, as well as hospitals.

**Proposed responsibility:** Commonwealth, State and Territory health ministers

(Relevant discussion Section 6.4.2)
Recommendation 18 — Lifelong learning and nursing competency
Given the challenging tasks undertaken by nurses and the rapid changes that can occur in technology, knowledge and skills, all nurses should be expected to undertake continuing education activities to maintain and enhance their professional competence and this should be taken into account in retaining registration or enrolment. To ensure this is possible:

a) employers should develop strategies in their local areas to provide the opportunity for registered and enrolled nurses to keep their nursing competencies current so that they can retain registration
b) employers could also provide opportunities to those not presently in employment to access appropriate fee-paying courses to maintain competency
c) nursing organisations should develop educational material to support the maintenance of nurses’ competencies in relevant areas.

Proposed responsibility: Employers, nursing organisations and individual nurses
(Relevant discussion Section 6.5.1)

Recommendation 19 — Models of preparation
To assure quality programs, undergraduate and enrolled nurse courses should continue to be accredited by State and Territory registration boards in accordance with national principles developed by the ANCI and endorsed by the NNCA. These principles should ensure that:

a) graduates from these courses meet the ANCI competency standards
b) quality assurance processes for course accreditation and the assessment of students are met
c) there is ongoing evaluation of the curricula and teaching practice in the light of changes in nursing practice, research on learning, and the broader developments in professional and para-professional preparation.

Proposed responsibility: ANCI in consultation with the NNCA
(Relevant discussion Section 7.1.3)

Recommendation 20 — Nurse academics and teachers
To ensure that students are exposed to current clinical practices, faculty practice should be:

a) built into the workload of those nurses who teach nursing students in universities and the VET sector
b) incorporated into annual performance appraisals.

Proposed responsibility: Education providers
(Relevant discussion Section 7.1.6)
Recommendation 21—Enrolled nurse competencies
To provide links to other training and to develop national consistency for the education and training of enrolled nurses:

a) the ANCI and Community Services and Health Training Australia should meet as a matter of urgency to ensure the ANCI competencies for enrolled nurses are incorporated in existing or new Australian National Training Authority sponsored training packages

b) in establishing the appropriate level of qualification, account should be taken of the training requirements for evolving models of care and changes in supervisory practice, including those related to medication administration and new enrolled nurse specialisations.

**Proposed responsibility:** Implementation taskforce
(Relevant discussion Section 7.3.1)

Recommendation 22—Minimum level of qualification for registered nurses
To ensure that registered nurses are appropriately prepared for their professional roles, the minimum level of qualification for entry to practice as a registered nurse should remain a university-based bachelor degree, with a minimum length equivalent to six full-time semesters.

**Proposed responsibility:** Commonwealth Department of Education, Science and Training, and State and Territory nursing registration boards
(Relevant discussion Section 7.4.1)

Recommendation 23—HECS for undergraduate nursing
To acknowledge the contribution that nurses make in the service of the community and the potential disincentive of increased course costs, all units that form part of undergraduate nursing courses required for initial registration should be classified at the minimum Higher Education Contribution Scheme (HECS) band.

**Proposed responsibility:** Commonwealth Department of Education, Science and Training, and universities
(Relevant discussion Section 7.4.4)
Recommendation 24—Clinical education funding

Since clinical education is an essential element of the preparation of all nurses and an area where the costs have increased to a point of being unsustainable, new quarantined funding over five years should be provided for clinical education in addition to the operating grant for undergraduate nursing courses. It should be administered through a new program, the Clinical Education Partnership Program.

The program should be formally evaluated in the fourth year to assess its impact and identify any changes that may be required for its continuing operation.

The program should meet the following criteria:

a) promote State- and Territory-based cooperative arrangements between those sectors preparing nurses for initial registration and those employing them
b) be acquitted in terms of delivering quality clinical placement outcomes (to defined minimum standards)
c) prioritise partnership arrangements and contributions from all sectors involved in health and education
d) promote innovative approaches to clinical education
e) include some assistance to students, particularly for those who are disadvantaged by the high costs of attending clinical placements.

Proposed responsibility: Commonwealth Department of Education, Science and Training

(Relevant discussion Section 7.5.3)

Recommendation 25—Commonwealth assistance for speciality and re-entry courses

The maintenance of nursing specialities and re-entry programs are important in meeting labour market needs. To enable these needs to be met:

a) an audit should be undertaken of the current postgraduate coursework scholarships, including those offered by the States and Territories
b) using the audit outcome and advice from the Australian Health Ministers’ Advisory Council (AHMAC) on shortages in specialised areas of nursing, recommendations should be made to the Commonwealth on the number of additional scholarships to be funded and the specialties to which they should be allocated
c) new scholarships should be offered for three years in the first instance, subject to review
d) specialised nursing areas where small numbers of graduates are needed should be identified and opportunities investigated for the contracting of these courses on a national basis
e) university-based units required for re-entry to nursing should be covered by a loans scheme.

Proposed responsibility: Implementation taskforce

(Relevant discussion Section 7.6.1)
Our duty of care

Recommendation 26—Remuneration for practice: postgraduate award course recognition
To acknowledge the value to the workplace afforded by nurses who undertake postgraduate courses relevant to their practice, appropriate remuneration should be provided to registered nurses who have completed a formal postgraduate award course and who are applying the related knowledge and skills in their employment.

Proposed responsibility: Commonwealth, State and Territory health ministers and other employers
(Relevant discussion Section 7.6.2)

Recommendation 27—Encouragement of inter-disciplinary and cross-professional approaches to education and practice
To encourage further developments in models of care and the education that supports them, government policy, funding and decision making in the health, education and training sectors should promote and support team-based approaches in education and practice.

Proposed responsibility: Commonwealth, State and Territory health and education and training ministers
(Relevant discussion Section 7.8.2)

Recommendation 28—Work organisation
Because the nursing workforce (including trained care assistants) contains a range of experience and skills, and because it needs to adapt to an evolving care environment, work organisation throughout the health, aged and community care sectors should:

a) constantly seek to achieve the most effective and efficient use of the total nursing workforce (including learning from best practice elsewhere)
b) ensure that skills and expertise are matched to the work required in the particular workplace
c) take account of the interrelationships with other health professionals
d) ensure that nurses are encouraged to practise to their full professional capacity.

Proposed responsibility: The NNCA and employers
(Relevant discussion Section 8.2.1)
Recommendation 29—Aged care nursing
To ensure that residents of aged care facilities have access to quality nursing care and that nursing in the aged care sector is an attractive option for nurses, Commonwealth aged care responsibilities and funding arrangements should enable professional nursing time to be focused on residents in aged care facilities by separating professional nursing documentation from the funding tool.

Proposed responsibility: Commonwealth Department of Health and Ageing
(Relevant discussion Section 8.3.2)

Recommendation 30—Workplace culture
To develop a constructive workplace culture, management in all health, aged and community care sectors, in consultation with staff, should establish and implement a suite of policies that encourage:

a) support for professional development
b) a positive work environment in which staff feel valued and are able to make their full contribution
c) multi-professional team work
d) workplace safety and cultural sensitivity
e) a work/life balance.

Proposed responsibility: Commonwealth, State and Territory health ministers and other employers
(Relevant discussion Section 8.3.5)

Recommendation 31—Workforce planning and data
Workforce planning is a vital component of future policy processes. It needs to be based on reliable valid data. Consequently the following are supported:

a) AHMAC’s ongoing work on nursing workforce planning which should proceed as a matter of priority to determine:
   i. the current size and composition of the nursing workforce—care assistants, enrolled nurses, registered nurses (general and specialist), and nurse practitioners—in the community, health and aged care sectors
   ii. the current and projected requirements of the nursing workforce in accordance with the priority determined by AHMAC following consultation with the NNCA
   iii. a method of nursing workforce planning that is proactive and, where appropriate, integrated with other areas of health workforce planning.

b) The ongoing work of the Australian Institute of Health and Welfare (AIHW) to establish and analyse data on the nursing workforce (including action to improve its currency) should proceed as a matter of priority.

Proposed responsibility: Implementation taskforce in consultation with AHMAC
(Relevant discussion Section 8.4.6)
**Recommendation 32—Health workforce research funding**

Australia’s workforce planning needs to be based on an integrated view of the workforce, developed using quality research tools. At the same time, recognition of the unique contribution of particular professions, such as nurses, must be understood. To promote this approach:

a) funding should be provided for further development of a robust methodology for all health workforce planning (including nursing), with consideration being given to the establishment of a research centre to undertake this work. Funding should be provided for five years in the first instance, subject to review

b) the methodology employed should draw on overseas research to further develop nursing indicators that are applicable in the Australian context.

**Proposed responsibility:** Implementation taskforce

(Relevant discussion Section 8.4.6)

**Recommendation 33—Commonwealth funding for additional undergraduate university places**

An increased supply of registered nurses is essential due to current shortages and the rapidly ageing nursing workforce. An initial short-term measure to achieve this outcome should include the following actions:

a) A benchmark for nursing commencement load based on the 2002 equivalent full-time student units (EFTSU) for non-overseas nursing commencements in each university (including direct-entry midwifery) should be set as the target for the following two years, with under-target load to be re-distributed to universities which have provided additional nursing EFTSU above the 2002 benchmark. The results to be reviewed after two years.

b) An additional minimum of 400 EFTSU for undergraduate nursing commencements should be provided for two years, beginning if possible in 2003, on the basis that:
   i. universities nominate for the additional places and provide evidence that this is an increase on the previous year’s total EFTSU for non-overseas nursing commencements
   ii. universities are able to supply quality clinical placements for all their nursing undergraduate students
   iii. the places are targeted to students who are able to gain advanced standing (such as enrolled nurses who wish to upgrade) and current undergraduates or graduates who wish to transfer to nursing.

**Proposed responsibility:** Commonwealth Department of Education, Science and Training

(Relevant discussion Section 8.4.9)
National Review of Nursing Education 2002

Recommendation 34—Expansion of opportunities in VET and VET-in-schools

States and Territories should expand opportunities for entry to enrolled nursing and occupations that do nursing work by:

a) providing additional training places for enrolled nurses to replace those upgrading to registered nurse within the State/Territory, and to meet shortages of enrolled nurses
b) promoting employment of student enrolled nurses through models of education and training such as traineeships
c) working with the Commonwealth to expand traineeships in rural areas as an entry to care work and nursing
d) supporting the expansion of VET-in-schools programs based on the Community Services or Health Training Packages
e) offering workplace trainer and assessor courses to nurses and recently retired nurses willing to assist in training or supervision of student nurses or trainees, particularly those in rural areas.

Proposed responsibility: Commonwealth, State and Territory ministers for education and training
(Relevant discussion Section 8.4.9)

Recommendation 35—Training places for Certificate III

To ensure that those workers involved in direct care work in the health, aged and community care sectors achieve a level of at least Certificate III in the appropriate Community Services or Health Training Package by 2008, a strategy should be developed to expand workplace assessment and the number of training places for Certificate III in the appropriate training packages.

Proposed responsibility: Commonwealth, State and Territory ministers for education and training
(Relevant discussion Section 8.4.9)

Recommendation 36—Nursing leadership and management

For nursing leadership and management to be enhanced:

a) governments should ensure improved representation of nurses on bodies which advise on both health and health education issues, so as to use more fully the expertise and knowledge of the nursing profession
b) workplaces should recognise and support the development of future nurse leaders and managers, using initiatives such as:
   i. mentoring and coaching, where experienced staff help younger or less experienced staff to develop and progress
   ii. involvement in policy development and implementation
   iii. provision of programs in areas such as human resources, financial management and policy development.

Proposed responsibility: The NNCA
(Relevant discussion Section 8.5.2)
1 Australian healthcare context

This chapter gives the Australian context for healthcare policy and the provision of the various care services. It also presents the changes and challenges that will impact on health, aged and community care service delivery. It provides a broad picture—the details of the models of care that are evolving as a response to these changes are discussed in Chapter 4.

The information supplied in this chapter comes from a range of data sources. Use caution when comparing different sets of data as they may be based on different assumptions or reporting periods.

1.1 Australian healthcare system

Australia's health system is complex with a mix of public and private provision and financing. It represents a major sector of the Australian economy with annual health expenditure amounting to over $47 billion in 1997–98 or around 8.3 per cent of GDP (AIHW 2000a). Health care is largely publicly funded, with governments providing around 70 per cent of health financing. The Commonwealth Government is the dominant funder (around 67 per cent of government health expenditure in 1997–98) (AIHW 2000a). In contrast, provision is largely private (65 per cent), supplied by medical practitioners and allied health professionals operating at the client interface, private hospitals and other health facilities (AIHW 2000a). Most government-delivered services are provided in public hospitals, for which States and Territories are responsible.

The Commonwealth subsidises the provision of health services through several national access programs—the Medicare Benefits Scheme for privately provided medical services and the Pharmaceutical Benefits Scheme (PBS) for pharmaceuticals. Funding for public hospitals is cost-shared between the Commonwealth and States through the five-yearly Australian Health Care Agreements. States and Territories are responsible for the delivery of public hospital and other population health type services. Provision of private health insurance is subsidised directly and indirectly by the Commonwealth Government.

An ongoing factor in the development of Australia's health system has been the appropriate division of responsibility between the Commonwealth and States and Territories. Under the Australian Constitution, legislative power with respect to health was not conferred on the Commonwealth and so remained with the States.

1.1.1 Developments and trends in Australia's health system

Australia's health system, like those of similar countries, has been changing. Key trends include:

- A shift in policy focus from providers and inputs of health care to patients and the outcomes of care.
- A search for ways to improve efficiency and effectiveness of service delivery and quality of health care in response to concerns about rising levels of government expenditure on health and resulting pressures on budgets.
- Growing recognition that safety and quality improvements are central functions of health care systems and the establishment of bodies to provide national leadership on these matters.
- Increasing focus on evidence-based practice and decision making.
• Strengthening information systems and evidence to improve performance monitoring and assessment and to provide reliable information to consumers, providers and governments.
• Recognition of the need for access to high quality research and development and cost effective ways to disseminate and translate research findings into practice.
• A shift away from institutional care to care in the home and community.

1.2 Health policy issues

In Australia, the combination of geography and population demographics presents particular challenges for our healthcare system. As well, Australia is a culturally diverse society. Australians are often described as being either Indigenous or non-Indigenous, but neither of these groupings is homogeneous. Apart from Indigenous peoples, we are a nation of immigrants, made up of different cultural groups, each of which may have its particular health issues. These and other factors provide a unique context for health policy and funding.

However, it is important to remember that Australia is also part of the global community. Health is a global public good. The health, education and training policies of other countries, along with the international labour market, all have an impact. These factors also provide a context for health policy and funding in Australia.

High standards in education and training create a workforce sought after by the international labour market. Globalisation has effectively erased the boundaries between labour markets and in response we have a mobile group of people with specialist skills who compete for work in an international field. Professionals make up the largest group of migrants (Stilwell 2002). As the competition for skilled workers increases, we may find it increasingly difficult to continue to attract these people.

1.2.1 Distribution of population

The Australian population is widely distributed across a continent of about 7 692 030 km², with the majority of the population concentrated on opposite coastal regions. The mainland spans a distance of about 3180 km from north to south and about 4000 km from east to west (ABS 2002). Half the area of Australia contains only 0.3 per cent of the population, and the most densely populated 1 per cent of the continent contains 84 per cent of the population (ABS 2002). Such a widely dispersed population provides a particular challenge for the delivery of healthcare services, particularly in Western Australia, the Northern Territory, South Australia and Queensland.
Most of the population in the coastal regions is concentrated in urban centres, particularly the capital cities. New South Wales is the most populous State followed by Victoria (see Table 1.1). However, the fastest population growth has occurred in the Northern Territory and Queensland, with increases of 10.1 per cent and 9.2 per cent respectively in the five years to 2000. In contrast, the population of South Australia grew by just 1.9 per cent over the same period and Tasmania declined by 0.7 per cent (ABS 2002). Table 1.1 compares the population at 30 June 2000 by State and Territory and by proportional distribution.

Table 1.1  Estimated resident population, by State and Territory (as at 30 June 2000)

<table>
<thead>
<tr>
<th></th>
<th>NSW '000</th>
<th>VIC '000</th>
<th>Qld '000</th>
<th>SA '000</th>
<th>WA '000</th>
<th>TAS '000</th>
<th>NT '000</th>
<th>ACT '000</th>
<th>Aust '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>6464</td>
<td>4766</td>
<td>3566</td>
<td>1498</td>
<td>1884</td>
<td>470</td>
<td>196</td>
<td>311</td>
<td>157</td>
</tr>
<tr>
<td>Per cent</td>
<td>33.7</td>
<td>25.0</td>
<td>18.6</td>
<td>7.8</td>
<td>9.8</td>
<td>2.5</td>
<td>1.0</td>
<td>1.6</td>
<td></td>
</tr>
</tbody>
</table>

Source: For population data, ABS 2000 b

In the first report on rural health by the Australian Institute of Health and Welfare (AIHW), Strong, Trickett, Titulaar and Bhatia (1998, pp. 5-11) note the following in relation to the socio-demographics of Australia today:

- Australia's Indigenous population is 1 per cent of the metropolitan zone and 3 per cent of the rural zone.
• There are substantial variations in the age structures of Australia's populations living in metropolitan, rural and remote zones. These differences reflect the varying patterns of fertility, mortality and migration experienced in each zone. The remote zone, with relatively higher proportions of Indigenous people, had substantially higher fertility rates than the rural zone in 1995. Remote centres experienced fertility rates around 25 per cent higher than large rural centres, and 40 per cent higher than capital cities.

• The proportion of people aged 55 years and over in the remote zone is around half that of metropolitan and rural communities. Migration from these areas and higher premature mortality of people living in the remote zone contribute to these lower proportions.

1.2.2 The immigrant population
Immigration has been a key factor in Australia's changing population, contributing to an increasingly culturally diverse nation. The proportion of the Australian population born overseas has increased from 10 per cent in 1947 to 24 per cent by June 2000 (ABS 2002). By the late 1990s, 91 per cent of the Australian population was of European descent and 7 per cent Asian (Hilless & Healy 2001). In 1999–2000, 34 per cent of all settler arrivals were from Asia (ABS 2002).

With almost one in four Australians born overseas and 27 per cent of those born in Australia with at least one overseas-born parent, the immigrant population has significant impact on health care in this country. The health status of the immigrant population also allows us to make a comparison on variations in morbidity and mortality with the Australian-born population.

The immigrant population is usually younger and in better health with a lower dependency ratio. Over three-quarters of all permanent arrivals to Australia in 1999 were between 15 and 64 years of age (AIHW 2001a, p. 28). Immigrants have better health than Australian-born residents on several measures including lower death rates, hospitalisation rates and various lifestyle-related risk factors.

The death rate among overseas-born persons in 1999 was 524 per 100 000 population, compared with 603 per 100 000 population among persons born in Australia. This is 13 per cent lower than the rate among Australian-born persons (AIHW 2001a, p. 29).

1.2.3 Indigenous population
The story for the Indigenous population is different from the wider Australian community. The life expectancy at age 65 is significantly lower than for the non-Indigenous population. Only 68 per cent of Aboriginal and Torres Strait Islander males can expect to live beyond 65 years compared with 84 per cent for all Australian males. Among Aboriginal and Torres Strait Islander females, 80 per cent can expect to live beyond age 65, compared with 91 per cent of all Australian females (AIHW 2001a, p. 41).

According to estimates based on the 1996 Census and its projections, there were 410 615 persons of Indigenous origin in Australia in 1999, constituting 2.2 per cent of the population. Between 1991 and 1999, the Indigenous population increased at an annual rate of 2.2 per cent. This contrasts with the total Australian population, which grew by 1.1 per cent annually (AIHW 2001a, p. 24).

The Indigenous population is quite young in comparison with the rest of the Australian population. In 1999, 50 per cent were under 20 years of age and only 3 per cent were aged 65 years or over. In contrast, 28 per cent of the Australian population as a whole were under 20 years of age and 12 per cent were aged 65 years or over (AIHW 2001a, p. 24).
Just over half of all residents in aged care services in all States and Territories other than the Northern Territory were aged 85 and over at 30 June 2001. Nationally only 4.5 per cent of residents in aged care facilities were under 65 years of age. In the Northern Territory 28 per cent of the residents in aged care services were aged 85 and over, while 19 per cent of them were under 65. This trend is due to the higher proportion of Indigenous Australians in the Northern Territory (AIHW 2002b, p. 3). Twelve per cent of residents in aged care services in remote areas were under 65 years of age (AIHW 2002b, p. 4).

1.2.4 Ageing population

A growing focus of government policy is the ageing population and its implications for Australia. The 2002–03 Budget Paper No. 5—Intergenerational Report circulated by the Treasurer, the Hon. Peter Costello MP, for the 2002–03 budget, states that Australia’s life expectancies are among the highest of OECD countries and that this is expected to continue. ‘In the past century, the proportion of the Australian population over 65 has risen from just over 4 per cent to nearly 12.5 per cent. By 2042, around 24.5 per cent of Australia’s population is expected to be aged over 65’ (Commonwealth of Australia 2002a, p. 19).

The growth rate of the older population is two to three times that of the rest of the population. The period from 1990 to 1999 saw the number of persons aged 65 years and over increase at an annual rate of 2.3 per cent. Those aged 80 years and over had an even greater growth rate of 4.1 per cent annually (AIHW 2000a, p. 40). Comparatively with other OECD countries, the 80 years and over age group will increase steeply in Australia due to the relative youth of the Australian population. Countries that have a similar profile to Australia are Ireland, Canada and the United States (Jacobzone et al. 2000). Table 1.2 compares the projections of growth rates in older citizens in Australia with the United Kingdom and the United States. Of note is the growth rate for men which is higher than that for women in all three countries.

| Table 1.2 Underlying demographic projections for average annual growth rates |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Australia 65–79 | 1.6     | 2.6     | 1.3     | 2.5     |
| Over 80         | 3.2     | 2.5     | 2.8     | 2.2     |
| Total over 65   | 1.9     | 2.6     | 1.7     | 2.4     |
| United Kingdom 65–79 | 0.6 | 1.2 | 0.2 | 1.1 |
| Over 80         | 1.3     | 1.0     | 0.9     | 0.7     |
| Total over 65   | 0.7     | 1.2     | 0.4     | 1.0     |
| United States 65–79 | 1.1 | 2.5 | 0.8 | 2.2 |
| Over 80         | 2.1     | 1.5     | 1.6     | 1.2     |
| Total over 65   | 1.4     | 2.3     | 1.0     | 1.9     |

Source: Table 2, Jacobzone et al. 2000

The population is ageing due to a peak in birth rate in the post-war period and an increase in the average length of life. While there is little evidence that the range of human lifespan is increasing (Fries, Green & Levine 1989), there has been a decrease in premature death. This decrease is due to improvements in nutrition, particularly maternal nutrition, environmental changes resulting from technological advances (for example, the storage of food), combined with advances in medical technologies (Singer & Manton 1998).
Ageing is a resource challenge because high levels of chronic illness and levels of disability accompany this process. In planning to meet the implications of the ageing population, policy makers will need a sophisticated understanding of the likely demands on resources due to requirements of care. A key question will be how to best invest resources in order to compress chronic illness and extend 'active life' (Fries 1980).

There is considerable evidence that early changes in behaviour towards a healthy lifestyle not only increase life expectancy but also the years 'lived in an active state' (Singer & Manton 1998). Further research suggests that there are benefits in changes in behaviour even late in life. Fries, Green and Levine suggest that 'it is in the pre-senior and senior populations that the greatest leverage for health promotion practices directed at chronic and degenerative diseases is to be obtained' (1989, p. 483). It seems that better health can be acquired not only through better lifestyles but also through appropriate access to new and costly technologies (Jacobzone et al. 2000).

Jacobzone, Cambois and Robine (2000) caution against taking the view that a decline in disability in the older population will result in savings. Even if further declines in disability could generate significant potential savings in the case of long-term care, this may not necessarily apply to health care costs in general, where public spending is generally of a much higher order of magnitude. The increase in health care spending in many OECD countries from 1980 up to the mid-1990s was, by itself, larger than the total spending on long-term care for a significant number of countries. Therefore, caution is needed in inferring links between improvements in health and healthcare spending.

The policy issues are complex. Australia may require investment in a wide range of areas, including social and health policy, to ensure a 'healthy ageing' of the population. Jacobzone and team believe that 'health and long-term policies can make a difference in transforming the pure demographic effect of ageing into very different social outcomes' (2000, p. 168). Further they argue that in developing and implementing policy, attention should be given to the range of factors that could influence the demand for long-term care. They note three factors:

- the living choices of older populations
- the perceived price of care in the community
- the potential availability of informal care, primarily from the spouse and children.

In relation to the last factor, they suggest that the availability of informal care could influence the demand for home help. They indicate that most international data shows that informal care could account for up to 80 per cent of total care currently undertaken. While in the past support from a spouse has been largely influenced by the greater likelihood of the female partner living longer than the male, the demographic projections of most countries suggest that there will be a re-balancing of male to female ratios with an increase in the lifespan of the average male (Jacobzone et al. 2000, p. 170). The availability of adult children to provide care in the future is difficult to predict in the changing work environment. While more family-friendly practices are proposed and work patterns are changing, the proportion of the population available for work is diminishing as the population ages.

Jacobzone and colleagues (2000) suggest that while a decline in the proportion of frail elderly people living in institutional care would pose a major challenge to social systems, it would also change the case mix in nursing homes. As has already been experienced in Australia, the future for nursing homes is likely to be one where older persons will require greater care as they are likely to be more disabled. The provision of this level of care may shift the required skill mix of carers in nursing homes. Table 1.3 shows the trends that have
occurred away from institutional care in Australia, which have had the effect of raising acuity levels in aged care institutions.

Table 1.3 Evolution of institutionalisation rates for Australia

<table>
<thead>
<tr>
<th>Men and women</th>
<th>Growth rate per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>3.0</td>
</tr>
<tr>
<td>Over 80</td>
<td>24.9</td>
</tr>
<tr>
<td>Total over 65</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: Table 4, Jacobzone et al. 2000

Jacobzone and colleagues use two different models to project the growth in the numbers of disabled older persons to the year 2020. One is a dynamic model, which projects past trends in institutionalisation rates or disability rates into the future; the other is a static projection, which assumes no change in institutional or disability rates in coming years. Table 1.4 provides projections based on both models for comparison. Both models project an increase in the number of older persons who will be institutionalised for care and an increase in those needing support in their homes between 2000 and 2020.

Table 1.4 Projections of numbers of disabled older persons to the year 2020 in Australia

<table>
<thead>
<tr>
<th></th>
<th>Dynamic model projections</th>
<th>Static model projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalised persons</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Disabled older persons in households</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Total disabled older persons</td>
<td>1.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: Table 5, Jacobzone et al. 2000

1.2.5 Changing demographics

Australia’s population is ageing and this trend will continue. At the same time, the rate of Australia’s population growth is expected to continue to decline, largely as a result of low and declining fertility rates and increasing numbers of deaths occurring in an ageing population. The Australian population is estimated to reach between 22.1 and 23.1 million by 2021 (ABS 2000a). Currently the population is around 19 million.

There are differing views about the impact of an ageing population on healthcare provision and costs with some commentators reporting that it will lead to a crisis in healthcare costs and expenditures. The OECD (1999) considers that the major risk to government finances in the long term comes from rising health care expenditure, mainly driven by underlying growth in real age-adjusted healthcare expenditure per capita rather than ageing.

1.2.6 Technological impact

Developments in science and technology have affected the health sector in a number of ways including:

- advances in prevention and diagnosis, as well as therapy, which have extended the scope of treatment
- shifts in the scope of practice for nurses
- new medicines
- an explosion in medical knowledge sourced from a wide range of discipline areas
opportunities to exchange information quickly and easily between medical staff and researchers
• faster turnover in hospitals
• a more informed public.

Advances in medical technology have added to the complexity of care delivered by health services. New technologies have led to significant improvement in patient management through accurate diagnosis and treatments. These advances in medical technology have helped people live longer and maintain a better quality of life. People now survive conditions that were once difficult or impossible to treat.

Improved testing methods and treatments (over recent years) include:
• premature babies now have a better chance of survival
• organ transplants are common and artificial organ transplants are becoming a reality
• people infected with HIV can now expect to live for years, rather than months due to the rapid introduction of antiretroviral drugs such as Kaletra. Such drugs cost about $10 000 per patient per year but are made affordable through the PBS. (Commonwealth of Australia 2002b, pp. 8–9)

The question for the planning of future health care becomes one of the best balance of expenditure to promote and extend the period of ‘active life’ for older Australians, those with disabilities and the good of the general community.

Pharmaceutical developments
The growing number of pharmaceuticals available has important implications for the healthcare system in general. As more medicines become available for treatment, the proportion of expenditure on pharmaceutical products in the health services budget has constantly risen. The proportional increase of pharmaceutical products to total health services expenditure occurred at the same time as a similar proportional decrease in hospital expenditure (see Attachment 1.1). The current discussion of the PBS in Australia is being driven by the rising costs to the Government (ultimately, the tax payer). As stated in the Intergenerational Report Overview:

Technology is likely to continue to advance— bringing substantial health benefits. But with more older people in the community— who use the most medicines— the costs will escalate. In 40 years’ time, the PBS could account for 3.4 per cent of the GDP, making it the largest part of the Commonwealth’s spending on health. (2002b, p. 9)

Jean de Kervasdoué noted that ‘In France, there are some 7000 prescription drugs based on some 3500 ingredients … If [a physician] prescribes six drugs, he/she must also be aware of some 720 potential sources on interaction. The figure reaches 3 328 800 if ten drugs are prescribed’ (OECD 2000, p. 183). The constant appearance of new drugs on the market increases demands on medical staff as they attempt to remain current. The representations in submissions to the Review on the development of a consistent core of knowledge about pharmacology in the nursing curriculum are also evidence of the impact of these developments.

Information access
The expansion of the Internet, with its online journals, databases and opportunities to discuss and exchange ideas, has allowed access to this information at levels not previously possible. Most clinicians in developed countries have access to the Internet and information is being increasingly disseminated through this tool. Medical practitioners,
from the smallest outposts to the largest research hospitals, are able to quickly and easily search for information, discuss problems with colleagues and share the results of innovative interventions. A challenge for Australian health is access to these sources in the more remote areas of the continent.

One way in which the new technologies are being used effectively in remote areas of Australia is through telemedicine. Doctors are now able to consult experts elsewhere and to transmit images and patients’ files to colleagues to obtain an opinion.

The emergence of the information age and the advent of the technology to support ‘remote’ care delivery in the community have also impacted on the way services are delivered. Information is a critical resource in the health system. It enables the integration across settings, reduces duplication and errors, and provides timely information. Professionals are increasingly reliant on information at the point-of-care to make decisions crucial to patient outcomes. (Aitken et al. 2001)

Telemedicine has become an enabling technology, expanding its original role of providing healthcare services in rural and remote areas to include home-care health services. Telemedicine is suddenly being recognised as a truly revolutionary force. Resulting from the merger of cutting-edge technologies in telecommunications and computers, it is redefining every health care relationship and transaction. It liberates medicine from the constraints of time and place that have prevailed since the age of Hippocrates. (OECD 2000, p. 180)

Harvey (2001), in reviewing the situation of e-health (telehealth, telemedicine and health informatics) in Australia, concluded that although a comprehensive policy framework has been developed, implementation to date has been ad hoc, incoherent and inadequately funded. The increase in the use of telehealth has implications for shifts in the scope of practice for nurses, an issue well documented in Aitken, Faulkner, Bucknall and Parker (2001). The authors note that nurses are leading consultations and/or being present to assist with examinations, providing patient education and manipulating or troubleshooting the telemedicine equipment. However, there was a paucity of Australian research available to the Review. Anecdotally, nurses in Australia, particularly in rural and remote areas, face a number of problems in accessing and capitalising on developments in e-health. These problems can range from lack of access to computers at their workplace, to lack of computer literacy or literature searching skills, or being ‘time-poor’ due to other demands. A marked increase in infrastructure and educational support is required before the advantages of all aspects of e-health are widely available to nurses in practice settings.

1.2.7 Acute care hospitals
Both the number of beds and the time patients spend in hospitals has decreased. The number of beds available in acute care hospitals has declined from 5.2 beds per 1000 population in 1987–88 to 4.5 beds per 1000 population in 1991–92 and 4.0 beds in 1998–99. This change was not evenly distributed between the government and non-government sectors, with the number of private acute beds increasing by 14 per cent.

The average length of stay in acute care hospitals in 1998-1999 was 3.7 days. However, if same-day separations were excluded, the average stay was 6.2 days. Average length of stay has fallen from 4.6 days in 1993–94 to 3.7 days in 1998–1999, representing an overall reduction of 19 per cent, or an annual fall of 4.2 per cent (AIHW 2001a, p. 97). The number of acute care hospital separations has grown from 257 per cent per 1000 population in 1993–94 to 294 in 1998–99, representing an annual growth rate of 2.7 per cent (AIHW 2001a, p. 96).

The decline in average length of stay is due to several factors. These include the better use of anaesthetics, less invasive surgical techniques and the expansion of early discharge programs enabling patients to return to their home to receive follow-up care. These advances have led to an increasing proportion of same-day patients, from 37 per cent in 1993–94 to 48 per cent in 1998-99. This rapid increase in the proportion of same-day separations has, in turn, led to rapid decreases in the overall average length of stay. Little change in average length of stay is noted if same-day separations are excluded from the data (AIHW 2001a, p. 97). While both the number of beds and the length of stay have declined, it is interesting to note the work of Karmel and Li (2002), which found that for acute hospitals 'while the length of periods in care declined by 17.5% the number of number admissions (on a population basis) increased by 15.1%.'

1.2.8 An informed public

New technologies have not only made the dissemination and exchange of medical information more available to those working in the field but have also increased the public’s awareness and knowledge of health care and their expectations of health services. As the public has become more aware, they have become more demanding and have higher expectations.

The access to information does not necessarily mean the public is well informed. Information is often out-of-date or based on promotional material, making it biased or without appropriate contextual background. The health consumer expects safer and more personalised health care, greater involvement in decisions about their treatment, and more choice and access to health services.

Consumer demand for new and more customised healthcare services will drive changes in the delivery, presentation and content of health care. Consumers will demand:

- choice
- autonomy in decisions
- access and advice
- control of personal information
- greater flexibility in the delivery of health services
- increased critical evaluation by consumers of the quality of health care.

(Leeder 1998, p. 3)

The Intergenerational Report notes that: ‘Consumers have a high demand for more effective treatments, and expect these treatments will be provided to them soon after the technology becomes first available’ (Commonwealth of Australia 2002b, p. 38). This increased consumer involvement has changed the roles of all the players in the healthcare system:
Whilst patients have traditionally been passive receivers of medical knowledge in the form of instruction and treatment by doctors and nurses, the wider dissemination of medical and clinical knowledge among patients can lead particular groups or individuals to inform themselves and to take issue with professional practitioners. Indeed, as the public becomes better informed through popular medical books, newspaper articles and television plays about hospitals, a new distribution of knowledge, and thus of power, is reflected in physician–patient relationships with patients, which become arenas for negotiation, rather than direction, over both diagnosis and treatment. Increasingly patients make the decisions, based on advice from medical staff, part of whose role is to supply the evidence relevant to any decision or choice. (OECD 2000, p. 46).

While well-informed consumers are in a good position to make decisions, the work of the nurse is often complicated by consumers who do not have the appropriate information or understanding of the complexities of their care in a given situation.

1.2.9 A litigious society

Rising expectations by the Australian health consumer have led to an increase in medical litigation when the outcomes fail to meet those expectations. The cost of medical malpractice insurance rose in Australia to the point where the biggest medical indemnity provider, United Medical Protection, collapsed in 2002, sparking a medical indemnity crisis. The Government put in place temporary arrangements to avert the disruption in medical services and on 30 May 2002 held a Ministerial meeting on public liability in an attempt to resolve the crisis.

The issues arising out of the crisis have repercussions for the delivery of health, aged and community care services and threaten the education and training of students in health-related disciplines such as nursing and medicine. The crisis is already affecting the availability clinical placements for nursing students in some universities. The Australian (Kerin & Keenan 2002) reported that students at the University of Queensland Medical School were unable to get insurance for their practical work and the situation was threatening student training. Uncertainty about who has liability when a student is involved in malpractice and the increased costs of indemnity insurance to education and training institutions may impact negatively on the availability of education in these areas.

1.2.10 Emerging diseases, health and social threats

New diseases are likely to continue to emerge while old diseases may reappear. Areas of public health such as hepatitis and AIDS have associated complexities of social stigma as well as disease management and patient care. Nurses need to develop all these understandings in their preparation as they will often be called upon to treat people who have these diseases or educate others about them. In doing so, they take on an important role of ‘knowledge broker’, both to interpret information and to assist in overcoming the discrimination associated with ignorance. We note the recommendation from the Anti-Discrimination Board of New South Wales in its Report of the enquiry into hepatitis C related discrimination that the National Review of Nursing examine the existing opportunities for education about hepatitis C for nurses and consider options for improving such opportunities’ (2001, p. 56).
1.3 Changing social and work environments

There is a growing societal expectation that there should be balance between working life, family and social life. An imbalance between work and other aspects of life can result in stress, poor physical and/or mental health of the employee, and workplace injury (CAALL Ad Hoc Committee on Work-Life Balance 2002).

In ratifying the International Labour Organization (ILO) Workers with Family Responsibilities Convention in 1981 Australia agreed to:

... make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities.


While some progress has been made towards providing more supportive 'family-friendly' working environments, projections by the ABS suggest that there will be even greater pressure in the future to respond to family priorities (1999a).

This issue is likely to become increasingly relevant. Australian government policy is beginning to encourage higher birth rates in response to the ageing of the population. The ageing of the population itself, and the associated care requirements of the older members of the population could also put further demands on the family and consequently require a more responsive employment environment.

Another important factor impacting on the work environment is the increased incidence of one-parent families. This increase has been projected to rise between 30 per cent and 66 per cent from 1996-2021 (ABS 1999a). The proportion of female one-parent families is expected to remain at five times the number of male one-parent families or possibly increase to six times the male one-parent families by 2021. For a predominantly female profession such as nursing, this increase in female-led, single-parent families means that workplaces will be forced to examine issues such as flexible working hours that reflect schooling requirements, childcare facilities that respond to 24-hour shift work, staffing arrangements around school holidays and the like.

1.3.1 Work patterns

The way Australians work and the type of employment are changing. Significant changes include:

- Between August 1988 and August 1998, there was a substantial increase in the proportion of casual employees, from 19 per cent to 27 per cent (ABS 1999b). In addition, there is now less constancy of hours and employment in the labour force generally (AIHW 1999b).
- Labour force projections show a significant increase in full-time and part-time employment at older ages as the ‘baby boomer’ generation moves toward retirement. The AIHW also reports an increase in the choice of self-employment for this group (1999a).
- Other modes of work such as project workers, home-workers, labour hire companies and seasonal workers are increasing.
- There has been a general decrease in the labour force participation rate for men compared to a general increase for women (AIHW 1999a). In recognition of the increased participation of women in the labour force, the age at which they can qualify for the age pension is progressively increasing from 60 to 65 years.
Few people work in the one labour area or for the one employer for life. Australians are more likely to change career a number of times throughout their working lives. Despite the ageing population, Australia still has a relatively young population compared to OECD countries. However the ratio of the over 65 years group as a percentage of working-age population is predicted to be 19.8 by 2010 and 29.4 by 2030 (Jacobzone et al. 2000, p. 152). Unless there is a considerable increase in numbers of young immigrants in future years, there will be a smaller proportion of population available for work. The combination of a smaller active workforce and early retirement could lead to a period of high competition between Australian employers to attract workers.

1.3.2 Work patterns and nursing

Many occupations have a history of gaining their new recruits from particular groups of the population. The main source of recruits for nursing has always been women and it remains a predominantly female profession. In 1997 only 7.7 per cent of all employed nurses (registered and enrolled) were male (AIHW 2001c). However, with a wider range of educational opportunities and career choices, the traditionally female career options such as nursing and teaching are now in competition with all other careers, many of which have more prestige and offer better remuneration. Nursing therefore faces a particular challenge in attracting new recruits who have greater choice than ever before.

In response to expanded opportunities, women are also participating more in education, which means a wide range of career options are available in many status occupations. More girls than boys complete high school to Year 12 or the equivalent (Office for the Status of Women 2001). In addition the number of women participating in higher education has grown steadily to the point where women today make up the larger proportion of students in Australian universities. According to the Office of the Status of Women (2001), in 2000 women made up:

- 57.9 per cent of students commencing a bachelors degree at university
- 51.2 per cent of enrolments in postgraduate studies
- over 50 per cent of enrolments in higher degrees by coursework.

The broad national trends in workforce patterns are reflected in the nursing workforce where there is evidence of an increase in the casualisation of the workforce and a greater use of agency staff in both public and private healthcare facilities. Aitken, Manias, Peerson, Parker and Wong noted in a submission to the Review that although a ‘mobile nursing workforce’ has existed in Australia and other countries for some time, there has been an increase in the use of casual labour and a significant move from full-time hospital employment to agency nursing. In this submission Aitken and colleagues suggest that, whereas agency staff were previously used to cover absences of permanent employees, there is an increasing reliance on their use in response to growing recruitment and retention problems.

Like all professionals, nurses are expected to engage in continuous skilling and lifelong learning. The skills and knowledge they develop are often transferable to other employment areas and, in keeping with the trend away from ‘jobs for life’, nurses are increasingly changing careers throughout their working life. Nursing also attracts people who have changed career and these people bring a new range of skills and knowledge to the profession. Nursing students who spoke to us during the consultation process indicated that nursing was their second or third career or even part of a transitional process leading them to a future career goal.

Saltmarsh, North and Koop (2001) examined the expectations of student nurses about their study and future career. The study found that students saw great benefits to be gained...
from a career in nursing as it presented opportunities to work in a variety of different roles within nursing itself, it facilitated a range of lifestyle options including working in different locations around the world, and it also offered a good foundation for other careers. There was a clear expectation that nursing was one step along a pathway, whether to particular areas of nursing specialisation or to a further career outside nursing.

1.4 Strategic direction

A number of countries are examining the challenges facing the future of health care. Of particular interest are those countries that have cross-jurisdictional arrangements influencing policy and funding, since this is the situation in Australia. Many of the issues raised in the Review show the need for more integrated planning across State and Territory boundaries in relation to factors influencing the delivery of health care. Moreover, the future challenges documented in this chapter suggest that Australia, along with various other countries, will need to engage in a community dialogue to find a way to balance resource demands. The reviews of the United Kingdom and Canada of their healthcare systems are of particular interest to Australia for these reasons.

In response to reduced investment over recent years, the United Kingdom has undertaken a wide examination of the way service is delivered in the healthcare sector. The NHS Plan: A plan for investment. A plan for reform, announced in mid-2001, is an integrated plan for improvement in the UK healthcare system. The NHS Plan provides an underpinning philosophy for decisions on scope of practice of health practitioners and their education. Nurses and midwives are specifically addressed and considerable expansion of scope of practice is envisaged for nurses. One of the principles outlined in the NHS Plan is the establishment of agreed protocols for service that encourage the best use of personnel. The NHS Plan also emphasises inter-disciplinary training and a common foundation program to enable students and staff to switch careers and training paths more easily. These developments should be monitored and assessed in the context of the UK health system.

Canada is currently undergoing a consultation process to determine how Canadians can create a sustainable future. In April 2001, the Privy Council of Canada established the Commission on the Future of Health Care in Canada. Its charter is to inquire into and undertake dialogue with Canadians on the future of the public healthcare system and recommend policies and measures for long-term sustainability (Romanow 2002). In the interim report the Commissioner reports that:

- Medicare, the publicly funded health ‘insurance’ system, needs remodelling
- the Canada Health Act needs to ensure it reflects the values of Canadians
- the lack of long-term, stable, predictable funding is jeopardising long-term planning and community confidence
- there is an absence of effective systems for sharing best practice (Romanow 2002, pp. 3–4).

The interim report canvases an interesting debate on the implication of values for the decisions that will underpin any changes in the future. This debate resonates well with the Australian context.

Both the UK and Canadian approaches highlight the need to plan for that future. While issues related to one professional group such as nursing are important, they need to be seen within the context of healthcare delivery. States such as Western Australia and Queensland have already developed or begun work on strategic health plans for the future—however, we need an Australian vision for health care based on community debate.
2 Nursing education and practice today

This chapter provides background information on international nursing trends. It documents the current arrangements for the education and training of Australian nurses and for those who directly support the work of nurses. It also examines the role nurses play in the health, community and aged care sectors, the challenges posed by changing conditions in education and health care, and the professional and regulatory arrangements related to nursing in Australia.

The information supplied in this chapter comes from a range of data sources. Use caution when comparing different sets of data as they may be based on different assumptions or reporting periods.

Nurses play an essential role in promoting and achieving the health outcomes of the Australian community. In many cases they form part of a team of health professionals and workers. The team in which they work may include nurses registered for different levels or types of practice contingent on their education and training and on the restrictions on practice imposed by legislation and regulation. Other nurses work in isolated situations where the community is dependent on their breadth of experience. Nurses also work in public health or community health areas as individual operators.

2.1 What is a nurse?

In Australia, nursing has two levels:

- the enrolled nurse, prepared through the vocational education and training (VET) system
- the registered nurse, prepared through the higher education system.

State and Territory nursing registration boards are at various stages in the development of another higher level within the registered nurse group, the nurse practitioner, which will have a regulatory framework that includes education and practice.

The growth of collective understandings, the ability to relate, to self-regulate and to set standards and systems of protection in place, mark the development of a profession (Kemmis 2001). Through its various bodies, the profession of nursing contributes to the education of nurses, to the regulation of practice, to practice development and to the continuing development and evolution of the discipline. Through these processes, the profession establishes itself in a way that it can contribute to the development of the healthcare system, its procedures and arrangements, and in the formation of policy.

Nursing is defined by its practice which, in turn, is characterised by distinctive traditions, skills, knowledge, values and qualities—that is, it forms a discipline. One of these values is ‘caring’. Defining this intrinsic nursing value is part of the development of the discipline of nursing as it evolves to meet the emerging needs of the community. Articulating that value to the community is one of the challenges nursing faces as it evolves to respond to very different practice environments.
Baumann and colleagues (2001) capture the essence of this challenge when they state:

While there is individual variation in how nurses see their roles, most nurses subscribe to a holistic philosophy of care and their work has most meaning when they are able to attend to all aspects of a patient's health. In the contemporary healthcare environment, the nursing model of caring often takes second place to a treatment-oriented medical model. Due to high workloads, nurses only have time for tasks related to patient's immediate physical needs. As a result they often become discouraged and feel guilty when they neglect patients' psycho-social and spiritual needs.

(Baumann et al. 2001, p. 9)

The changing nature of hospitalisation makes it increasingly difficult to work as a 'carer' (White 2001). The rapid turnover of patients means there is less time spent in hospital preparing for surgery and recovering. Some restructuring of work has left nurses more involved in care planning and coordination than in care delivery—and feeling distanced from patients as a result. Both factors—the speed of turnover and the restructure of work—affect patients' experience of care and create tensions for a profession that has developed the sort of collective understanding detailed above.

2.1.1 Who does nursing work?

One of the most contentious issues raised throughout the Review is nursing work and the right to use the title 'nurse' in the current environment in Australia. All States and Territories protect the titles 'registered nurse', 'enrolled nurse', 'midwife' and, where applicable, 'nurse practitioner'. In addition, the use of the title 'nurse' is protected by legislation in four of these jurisdictions.

While enrolled and registered nurses are regulated, there is a wide range of other workers undertaking direct patient/client care work that could be described as nursing work. The majority of unregulated/unlicensed carers are currently in the community and aged care sectors. The development of some health training packages is also beginning to challenge some of the nursing work boundaries in acute care settings with the introduction of technicians with diploma qualifications.

The unregulated/unlicensed care worker is given many titles in the aged and community care sectors. These include 'assistant in nursing' (AIN), 'personal care assistant' (PCA), 'aged person carer' and 'disabled person carer'. Debate about a consistent title for these workers—whether it should identify them as working in the domain of nursing or not—continues. Resolution of this issue has a range of ramifications, including workforce planning, industrial coverage and protection of the public. Without a common nomenclature it is difficult to count those contributing to nursing work, and impossible to establish standards that cover their work.

While we advocate an agreed name, we do not take a position on what nomenclature is appropriate. For simplicity, throughout this report this group of workers will be referred to as 'trained care assistants'. This choice of title is not to prejudice the debate on the issue or decisions about the industrial coverage of these workers. It is designed to acknowledge the role these workers have in caring for those who need assistance in matters of direct personal care regardless of the setting.

The term 'trained care assistant' will be used in the report except for the following circumstances:

- where a particular statistical category is being discussed
- in the recommendations
- when we are talking about care assistants requiring training.
2.1.2 Nursing workforce
We have included the following groups when discussing the nursing workforce:
  • nurse practitioners
  • nurse managers
  • registered nurses (general and specialist), midwives and mental health nurses
  • enrolled nurses
  • nurse educators (working in hospitals, universities and the vocational education and training sector)
  • trained care assistants.

Midwives and mental health nurses
The situation regarding midwives and mental health nurses varies across Australia. In one State registered nurses must have special registration to practice as a mental health nurse or require supervision by a registered mental health nurse. In some jurisdictions there are restrictions on the practice of those nurses trained only to be registered mental health nurses under previous direct entry education arrangements. At present registered nurses must gain an additional qualification to register or be endorsed to practise as a midwife.

Universities in South Australia and Victoria introduced direct entry undergraduate programs in midwifery in 2002 and other universities plan to do so in the near future.

The terms of reference for the Review assumed that midwifery would be covered under nursing specialisations. Consequently, midwives are discussed throughout this report as an integral part of the nursing workforce. We acknowledge the growing debate about the nature of midwifery, but we believe this is an issue for the profession, with all its members, to resolve. While we note the strong representation to change the title of the Review to 'nursing and midwifery', we also observe that none of the National Nursing Organisations have yet changed their names to reflect the inclusion of midwifery.

2.2 International nursing
The terms of reference require the Review to have regard to the work of current research projects and reviews such as the New Zealand review of nursing education, the Australian Health Workforce Advisory Committee nursing workforce review, and the British review of funding for nursing. The findings of the international reports and reviews are summarised in Attachment 2.1. The relevant Australian reports are discussed in the appropriate place in the text of this report. Keeping current with the many reports and activities, both internationally and in Australia, has been a particular challenge for us throughout the review due to the level of activity, and apart from the report of the Senate Inquiry, we have not included any new reports or findings since 14 June 2002.

An interesting monitor of the importance of nursing on the international arena has been through the agendas of the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO). Many countries are facing shortages in the supply of nurses and their concerns have raised the visibility of nursing. A number of trends have appeared in international nursing reports and activities which include:
  • attempts to take a more coordinated strategic approach to nursing at the national level
  • a focus on upgrading the education of nurses
  • investment in nurses
  • attempts to establish or build more sophisticated workforce planning processes.
2.2.1 International trends

The following information gives some examples of the approaches in different countries and organisations. More information is at Attachment 2.1.

National strategic nursing approaches are evident in the developments in a number of places including Canada and the United Kingdom. In 1999, the Conference of Deputy Ministers of Health directed the Advisory Committee on Health and Human Resources to develop a strategy for Canadian nursing. As part of the strategy they appointed a multi-stakeholder Canadian Nursing Advisory Committee to give priority to providing advice on improving the quality of the work life for nurses. The National Health Service (NHS) plan for the United Kingdom also provides a national framework for the development and resourcing of nursing as part of the health workforce (NHS 2000).

The quality and level of education required for nurses are the focus of a number of activities. Part of the development of a WHO European Strategy for nursing and midwifery includes fundamental principles for initial and continuing education of nurses and midwives (WHO 2001a). These principles identify the entry to practice qualification of a nurse or midwife as a university degree in nursing or midwifery. Ireland, in response to its Commission on Nursing report (1998), is in the process of transferring all nursing education into the universities. The province of Ontario, Canada, has a target that the entry to practice will be a Bachelor of Science (Nursing) by 2005 (Ontario Ministry of Health 1999).

Considerable investment in the education and salaries of nurses is part of various strategies by the British Government, which aims to increase the supply of nurses from initial training and other sources such as migration in order to provide an additional 35,000 nurses by 2008. Large investments in nursing are also part of initiatives by provincial governments in Canada. The plans include bursaries for nurses to upgrade in Saskatchewan, reduction of the workload of mentors of graduate nurses and funding for the education of more specialty nurses in British Columbia, and additional nursing positions to provide floating relief staff in Prince Edward (Baumann et al. 2001, Appendix B).

The development of the workforce planning process has been another strategy in response to nursing shortages. Of particular interest is an OECD project that plans to explore which human resource policies for health care best contribute to the efficient and effective delivery of health services across OECD health systems. More information on this project is in Chapter 8.

As stated above, a number of countries have shortages of nurses. Countries reporting shortages include Zimbabwe, India, Vietnam, the United States, the United Kingdom and Canada. Zurn, Dal Poz, Stilwell and Adams (2002) document reports from different countries related to the supply of nurses. The comparison of nurses per one million population in Europe and Africa shows the relativity of the concept ‘shortage’. While nursing shortages have been reported in both Africa and Europe, there is substantial variation in the nurse-population ratio of countries in these regions. On the basis of WHO data, the highest nurse-population ratios were in Finland and Norway. After these leading countries, Malta and Belgium had similar nurse-population ratios, but they were about half that of Finland. The United Kingdom, Spain and France also had similar nurse-population ratios but again these were about half those of Belgium (Zurn et al. 2002, p. 6). Of particular interest is the fact that some of these countries, including Canada and the United Kingdom, have an expectation that they will need to attract nurses through immigration.
2.3 The Australian nursing workforce and related occupations

The Review commissioned a research study to investigate job growth and turnover in nursing occupations in the period 2001–2006 (Shah and Burke 2001). This section and Attachment 2.2 are based on that work. The definition of 'nursing worker' used by Shah and Burke is more restricted than that used in the rest of this report when discussing the 'nursing workforce' due to categories used in the data source. The need to explain this here highlights the challenges presented in trying to understand the nursing workforce in Australia.

In this section, 'nursing workers' are defined to include the occupations of directors of nursing, nursing professionals, enrolled nurses, and personal care and nursing assistants. Separate analysis is included on aged or disabled person carers, an occupation that the Australian Institute of Health and Welfare (AIHW) excludes from the nursing workforce. Details of the models used by Shah and Burke for their investigation, the assumptions underpinning them and the data used to estimate them are not included here, but are available in their paper which is available on the Review website. The paper also provides a detailed picture of the employment and demographic changes that have occurred in each of the above occupations over the last decade and a half. These include age and gender profiles and hours of work.

Table 2.1 shows employment changes in the different nursing, aged and community care occupations between 1987 and 2001. The table shows two nursing occupations, enrolled nurses and personal care and nursing assistants, with negative growth over this period.

Table 2.1 Change in employment in nursing and aged and disability person carer occupations, Australia, 1987–2001

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment level 2001 ('000)</th>
<th>Total growth 1987–2001 (per cent)</th>
<th>Annual growth rate (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All occupations</td>
<td>9090.4</td>
<td>29.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Nursing workers</td>
<td>248.4</td>
<td>17.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Directors of nursing</td>
<td>2.7</td>
<td>74.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Nursing professionals</td>
<td>183.9</td>
<td>29.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>22.5</td>
<td>-20.6</td>
<td>-1.2</td>
</tr>
<tr>
<td>Personal care &amp; nursing assistants</td>
<td>39.3</td>
<td>-1.7</td>
<td>-0.2</td>
</tr>
<tr>
<td>Aged and disabled person carers</td>
<td>71.0</td>
<td>424.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Note: The average annual rate was estimated by fitting a log linear model to the annual employment data. Except for personal care and nursing assistants, all other estimates are significant at less than 10 per cent level.

Source: Shah & Burke 2001

Changes in the relative proportions of the three main groups classified as nursing workers—nursing professionals, enrolled nurses, and personal care and nursing assistants—suggest the growth in the first group has been at the expense of the other two groups. This pattern of substitution is not uniform across States and Territories and does not take into account the aged or disabled person carers. The employment of this latter group grew in all States and Territories. Karmel and Li (2002) note:

the importance of the missing group (missing because we do not have the data to include them in the analysis: nursing assistants and personal carers. Presumably, the reason that the ratio of nurses to patients has declined is because some of the work of nurses has increasingly been undertaken by this group.
2.4 Nursing shortages

The nursing shortages in hospitals have consequences not only for patient outcomes but also for education outcomes. In an environment where nurses are trying to respond to high demands on service, there is little time or energy to take on professional roles with students, or with other staff. A measure of the current climate is the information on vacant positions or positions difficult to fill.

Reference to the National and State Skill Shortage Lists at February 2002 show that the problem of shortages appears to have increased in some States since the commentary in the Review’s Discussion Paper (National Review of Nursing Education 2001, pp. 83–86). These lists are based on labour market intelligence undertaken by the Department of Employment and Workplace Relations (DEWR).

At March 2001, and again at February 2002, the lists showed a number of nursing categories in which shortages were reflected nationally (Table 2.2). The actual nursing specialisations experiencing shortages did not change between the two reports. However, there were changes in individual categories across States and Territories. For Queensland, South Australia and Western Australia, the February 2002 report now shows shortages against all categories of nurse specialisations, which was not the case in March 2001.

Table 2.2 Shortages of registered nurses by specialisation and enrolled nurses—March 2001 & February 2002*

<table>
<thead>
<tr>
<th>Nursing occupation</th>
<th>AUS</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
<th>NT</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse (general)</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Accident/Emergency</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Aged care</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Community</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Critical/Intensive care</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Indigenous health</td>
<td>R (R)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Neo-natal intensive care</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Neurology</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Oncology</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Operating theatre</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Paediatric</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Palliative care</td>
<td>N (N)</td>
<td>D (D)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Perioperative</td>
<td>N (N)</td>
<td>S (S)</td>
<td>D (D)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>N (N)</td>
<td>S (S)</td>
<td>D (D)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>N (N)</td>
<td>D (D)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>N (N)</td>
<td>S (S)</td>
<td>D (D)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Registered midwife</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Registered mental health</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td>N (N)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
<td>S (S)</td>
</tr>
</tbody>
</table>

* February 2002 data is shown in brackets

N = National shortage  S = State or Territory wide shortage  D = Recruitment difficulties  R = Regional shortage (outside capital city only)

2.5 Changing nursing worker profile

While it is difficult to identify all the factors that may impinge on the future demand for nursing workers, two likely to be of importance are the ageing of the nursing workforce and the shift towards working shorter hours.

Nursing workers are older now than they were in 1987. The proportion of workers aged 45 years and over increased by 17 percentage points between 1987 and 2001 and the under-34 age group decreased from 54 percentage points to 30 percentage points. The norm for retirement of nursing workers is around 55 years. Consequently, the large increase in the 45–54 age group and the enormous decrease in the under-34 age group suggests that the ageing of this workforce will continue for some years, resulting in a significant impact on demand due to high numbers of retirements.

Table 2.3 shows that ageing has occurred at different rates across nursing and carer occupations. The proportion of registered nurses aged 45 years or older nearly doubled between 1987 and 2001, but the proportion of registered midwives in the same age bracket increased by only five percentage points. The proportion of aged or disability person carers aged 45 years or older increased from 19 per cent in 1987 to 45 per cent in 2001.

Table 2.3 shows increasing proportions of directors of nursing, registered nurses, registered midwives, enrolled nurses and personal care and nursing assistants are working part-time. On the other hand, increasing proportions of nurse managers, nurse educators and researchers are working full-time.

The pattern in the shift towards working shorter hours in some nursing occupations is unlike the pattern that can be observed for the labour force in general. In general, the shift in hours has been from the normal full-time hours towards very short or long hours, but in the case of these nursing occupations the shift has been more from the normal full-time hours towards working 16–34 hours per week.

Table 2.3 Summary statistics of employment in nursing and carer occupations by age and hours worked per week, Australia, 1987 and 2001

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors of nursing</td>
<td>71</td>
<td>71</td>
<td>87</td>
<td>84</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>22</td>
<td>45</td>
<td>54</td>
<td>75</td>
</tr>
<tr>
<td>Nurse educators &amp; researchers</td>
<td>26</td>
<td>34</td>
<td>37</td>
<td>49</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>20</td>
<td>38</td>
<td>55</td>
<td>49</td>
</tr>
<tr>
<td>Registered midwives</td>
<td>20</td>
<td>25</td>
<td>53</td>
<td>31</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>15</td>
<td>35</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>Personal care and nursing assistants</td>
<td>26</td>
<td>37</td>
<td>53</td>
<td>43</td>
</tr>
<tr>
<td>Aged and disability person carers</td>
<td>19</td>
<td>45</td>
<td>39</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: Shah & Burke 2001
2.6 The nursing workforce and education

Australian higher education and VET qualifications are brought together under the Australian Qualifications Framework (AQF). The AQF encompasses the whole range of qualifications from school and VET, through to university and other higher education institutions, and is endorsed by the Australian Government.

While the issuing of some qualifications is the preserve of a discrete sector, other qualifications are issued in more than one of the three sectors: schools, VET or higher education. Certificate II and III are available through the VET sector, and in some cases the school sector for various health and community workers. At the current time, enrolled nurses usually complete Certificate IV or a diploma in the VET sector and new registered nurses require a university bachelor degree and may then complete higher awards such as graduate certificates, graduate diplomas, masters degrees and doctoral degrees in universities. Midwives normally complete a Bachelor of Nursing and follow this with a postgraduate qualification, but as of 2002 new entrants may undertake a Bachelor of Midwifery in some States without any nursing qualifications.

Table 2.4 provides a summary of these arrangements and links them to the AQF. The inclusion of trained care assistants gives recognition to the relationship with nursing and to the pathways already being used to gain nursing qualifications.
Certificate II courses are not included in this diagram as we believe that the minimum qualification for those involved in care work should be Certificate III. Certificate II courses do provide some exposure to the industry and are often in school/VET programs.

The following sections provide commentary on both the roles and models of education and training of the trained care assistant, the enrolled nurse, the registered nurse, the specialist nurse and the nurse practitioner.

### Table 2.4 Overview of models of education and training related to nursing within the Australian Qualifications Framework

<table>
<thead>
<tr>
<th>Australian Qualifications Framework</th>
<th>Title</th>
<th>Models of education and training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate</td>
<td>Doctor of Philosophy</td>
<td>Doctor of Philosophy</td>
</tr>
<tr>
<td>Doctor of Philosophy/Professional</td>
<td>Doctor of Nursing</td>
<td>Doctor of Nursing</td>
</tr>
<tr>
<td>Doctorate</td>
<td></td>
<td>Research</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>Midwife (on completion of Diploma or Masters)</td>
<td>Masters by research or coursework</td>
</tr>
<tr>
<td>• Masters</td>
<td></td>
<td>Courses embedded—</td>
</tr>
<tr>
<td>• Diploma</td>
<td></td>
<td>Cert Diploma/ Masters with exit points at each level if desired</td>
</tr>
<tr>
<td>• Certificate</td>
<td></td>
<td>Free-standing courses at each level</td>
</tr>
<tr>
<td>Bachelor</td>
<td>Registered nurse/ Division 1 nurse</td>
<td>Double degrees</td>
</tr>
<tr>
<td>• Midwife</td>
<td></td>
<td>Six semesters courses (2-3 years)</td>
</tr>
<tr>
<td>• Masters</td>
<td></td>
<td>Eight semester courses (with or without honours)</td>
</tr>
<tr>
<td>• Diploma</td>
<td></td>
<td>Graduate entry programs</td>
</tr>
<tr>
<td>• Certificate</td>
<td></td>
<td>Enrolled nurse entry programs</td>
</tr>
<tr>
<td>• Masters</td>
<td></td>
<td>One year entry for registered hospital trained nurses with</td>
</tr>
<tr>
<td>• Diploma</td>
<td></td>
<td>lapsed registration</td>
</tr>
<tr>
<td>• Certificate</td>
<td></td>
<td>Hospital trained (1 year)</td>
</tr>
<tr>
<td>• Masters</td>
<td></td>
<td>Diploma upgrade (1 semester)</td>
</tr>
<tr>
<td>Diploma</td>
<td>Enrolled nurses (Queensland)</td>
<td>Employment contact with TAFE course (eg NSW traineeship)</td>
</tr>
<tr>
<td>Level V Certificate (Advanced</td>
<td>Enrolled nurse (Advanced Certificate)</td>
<td>VET training with clinical placement (TAFE or private provider)</td>
</tr>
<tr>
<td>Certificate)</td>
<td></td>
<td>New Apprenticeship—on and off job training</td>
</tr>
<tr>
<td>Level IV Certificate</td>
<td>Enrolled nurse/ Division 2 nurse</td>
<td>Traineeships for school students</td>
</tr>
<tr>
<td>Level III Certificate</td>
<td>Trained care assistant</td>
<td>Traineeships postschool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>On job training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Course with clinical placement (full or part-time)</td>
</tr>
</tbody>
</table>

Note: Certificate II courses are not included in this diagram as we believe that the minimum qualification for those involved in care work should be Certificate III. Certificate II courses do provide some exposure to the industry and are often in school/VET programs.
2.7 Meeting the needs of the student

Considerable development has taken place in recognising a range of qualifications and experience in selection for entry to nursing degrees, and in the flexible delivery of courses. Students come from a range of backgrounds and different experiences. Figures A2.3.1 and A2.3.2 in Attachment 2.3 give an overview of the diverse pathways into university nursing education and then to employment.

Clare, White, Edwards and van Loon (2002, p. 2), in the summary of their study conducted for the Australian Universities Teaching Committee, comment on this flexibility:

Of note was the trend towards increasing flexibility of student entry (particularly for enrolled nurses, Aboriginal and Torres Strait Islander students, overseas-born and mature students) and of curricula delivery (particularly distance education) although there remains room for improvement. Also of note was the emphasis in most courses of increasing student intellectual development leading to the incorporation of more independent learning activities as the student progress through the course. The inclusion of subjects such as ethics, law, politics, communication, health care context and social and political theory strengthened this finding.

Ogle, Bethune, Nugent and Walker (2001) report that although institutions had difficulty providing accurate data on part-time versus full-time study due to students moving randomly between the two modes of study, about 82 per cent of undergraduate pre-registration students were full-time, while post-registration undergraduate students (generally students doing honours and hospital-trained nurses upgrading) utilised a mixture of full-time and part-time study.

Australian universities have also provided students with additional flexibility by offering nursing programs through distance education. Some components of undergraduate nursing are offered by distance or Internet courses through 13 universities (Ashenden & Milligan 2002). Distance education is generally delivered by a variety of methods such as print-based material, videos, teleconferencing, videoconferencing and residential schools. Universities are now making increasing use of the technologies available through the Internet to provide learning.

2.7.1 Online education

Advocates of online education suggest that it has a number of benefits for students including increased access to resources, enhanced learning through simulations, multimedia and interactive content, and increased ease in communication with educators, researchers and other students outside the restraints of time or place.

In 2001 DEST conducted a study of the extent of online education in Australian universities. There were significantly fewer undergraduate online courses (17) than postgraduate courses online (187). Only five undergraduate courses were delivered only by online mode, whereas 58 postgraduate courses were delivered only online.

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3 For the purpose of this survey, a course is defined by DETYA (2001) for its statistical collection as a program of study formally approved or accredited by the institution or any other relevant accreditation authority and which leads to an academic award granted by the institution, or which qualifies a student to enter a course at a level higher than a bachelor's degree.

A unit is defined as the basic unit of a course or program, which a student may undertake and on successful completion of the unit's requirements, gain credit towards completion of the course or program. Units of study are sometimes referred to as 'subjects'.
Though there were few online courses at undergraduate level, over half (55.6 per cent) of all undergraduate units currently contain an online component. Most of those units were web-supplemented rather than web-dependent or fully online and 44.5 per cent of units in the broad Health discipline were web-supplemented (Bell et al. 2002).

It is important to remember that the use of information and communication technologies in teaching and learning is a relatively recent practice and much more research needs to be done on the pedagogy, quality and cost effectiveness of online education.

Online learning is bringing about fundamental changes to the delivery of education and training and has even affected the way people learn. For many, it contributes to an enriched learning experience, while for the 'time poor', the availability of online learning is of enormous benefit. However, online learning is not the complete panacea that many originally envisaged. (Bell et al. 2002).

With the expansion of this mode of delivery the concerns of rural students should be noted. In their submission to the review, the Association of Australian Rural Nurses commented:

It is becoming increasingly popular for education providers to offer education using web-based learning material. While the arguments for the uses of this technology are sound (Gray 1994), they are problematic for many rural nurses. Many rural communities lack the efficient tele-communication facilities found in urban and provincial areas, and the associated costs for students to purchase hard and software combined with inadequate access to local computer support, means that this mode of delivery is often ineffective. (Submission No. 57)

Increased flexibility in mode, delivery and selection criteria may hold many advantages for the education consumer, but these factors may affect the likelihood of completion of study at university. In their study of university completion rates, Urban, Jones, Smith, Evans, MacLachlan and Karmel (1999, p. 1) suggest that full-time students have the highest completion rates and external students the lowest completion rates.

Tertiary Entrance Rank (TER) is a significant indicator of completing a university course. Of students entering university on a basis other than TER, those with previous higher education experience and professional qualifications have the highest completion rates. These findings should be a caution for the way nursing education programs develop in the future.

Another caution in the development of nursing courses for undergraduate students is finding the appropriate balance between distance or online provision versus face-to-face delivery for a practice profession. Defining the balance will need further research and the monitoring of developing practices in this area.

The VET sector is responding to student needs through the application of information technologies and communications in its programs. The CEOs of the Australian National Training Authority (ANTA) endorsed the Australian Flexible Learning Framework (AFL Framework) in 1999. This framework drives improved access to and increased take-up of flexible learning by training organisations across the public, private and community sectors. In Strategy 2002, ANTA notes the progress they have made to date:

- Quality online content has been developed and applied to make vocational learning programs more flexible.
Thousands of VET practitioners across Australia have been actively learning and creating knowledge through participation in innovative developmental projects sponsored through the AFL Framework.

A substantial body of research is being created and applied to policy and practice. In particular, knowledge about the different needs of different learners is informing the production of content and the application of online learning methodologies.

Commitment to flexible learning is growing amongst providers.

National and international communities of interest for e-learning are strengthening and expanding.

(ANTA 2002, p. 1)

2.8 Registered nurses

A registered nurse is a person licensed to practise nursing under an Australian State or Territory Nurses/Nursing Act (ANCI 2001). Nurses make up over half the health professional workforce (Duckett 2000). According to Shah and Burke (2001), the employed number of nursing professionals was 183,900 in 2001. Just over 51 per cent of registered nurses worked in acute care/psychiatric hospitals in 1997 (AIHW 2001d).

2.8.1 Initial education of registered nurses

The year 1994 marked the end of the transition from an apprenticeship model of registered nurse training to an academic model of nursing education. The State and Territory Governments contributed funding to the Commonwealth education portfolio in that year. Under the transfer agreement, the States and Territories provided 75 per cent of the average funding rate for a nursing place through offsets to State and Territory grants. Considerable information about the shift from hospital training to university education for registered nurses is documented in the 1978 Committee of Inquiry into Nurse Education and Training Report (Sax, chair) and the Report of national review of nurse education in the higher education sector: 1994 and beyond (Reid, chair). Since that time all registered nurses in Australia have been educated to a bachelor degree level at university. In addition to requiring a bachelor degree in nursing, graduates must meet the Australian Nursing Council Incorporated (ANCI) competencies for registration in their State or Territory. All pre-registration nursing curricula must have accreditation from the State or Territory nursing registration board as well as meet the university’s requirements for course approval.

Funding

Once the transfer was complete, the Commonwealth education portfolio assumed the funding of undergraduate nursing courses in higher education. The funding level initially differed between institutions as it was based on an agreed transfer cost between the States and Territories and the Commonwealth. Current funding arrangements treat nursing within the general operating grant model, that is, as any other course at the university. Under this model, universities receive an operating grant based on their teaching profile and are expected to provide a given number of equivalent full-time student units (EFTSU) for the funding. Details of the funding model can be found in the Review’s Discussion Paper at pages 136–139.
Undergraduate nursing students may be fee-paying or may fall under the Higher Education Contribution Scheme (HECS). There are few fee-paying Bachelor of Nursing students. In the 2000 Department of Education, Science and Training (DEST) statistical collection, the units recorded were all at Avondale College which does not have any HECS places for nursing. At the University of Notre Dame, another private higher education institution, most nursing students are fee-paying. The University now has a small number of HECS-funded EFTSU allocated for the Broome campus. Some of these are for nursing. The University of Notre Dame nursing students are not included in the statistics quoted from DEST but are included in information reported from the work of Ogle and team in this section. The University currently has 156 undergraduate nursing students. In addition to these few fee-paying places, at least one State health department provided funding for undergraduate nursing places in 2002.

Undergraduate student numbers

The general trend in domestic (non-overseas) undergraduate nursing is for a decrease in both commencing student numbers and the EFTSU load allocated to nursing within universities. (The difference between EFTSU and number of students is due to the proportion of part-time students.) In 1998 there was a slight reversal of the trend, but the decrease continued in 1999 and 2000. The number of domestic commencing nursing students fell from 11,274 in 1994 to 8,248 in 2000. Some of the decrease can be accounted for by the reduction in the number of nurses upgrading from hospital training to a degree, but it is not all due to this factor.

During the early part of the period 1994–2000 there was some difficulty in finding work in nursing (see Section 6: Graduate Destination Survey in DEST 2002b). The level of interest in nursing as a career appeared to drop and with it applications to the universities across much of the period (see Section 8: Applications and Offers for Nursing Courses in DEST 2002b).

Although the official DEST statistics have a category called ‘basic nursing’ to identify pre-registration students, there are some anomalies in the data due to misclassification by the universities, so the category we have used here is ‘undergraduate’. Ogle and colleagues (2001 and 2002) attempt to separate the two groups (pre-registration and post-registration) and also to provide more current estimates of completions than are available from DEST.

Ogle and team report university undergraduate commencements for pre-registration domestic students in 2001 and 2002 at 7,597 and 8,305 respectively. This increase is due to growth in most States and Territories, but particularly in Queensland. They also report completions for pre-registration domestic students for 2001 were 5,219 and post-registration undergraduate domestic students were 466 (Ogle 2002, Table B8). Universities project completions for pre-registration domestic students to be slightly higher in 2002 than those in 2001, largely due to an increase in student numbers in Victoria. Other States and Territories, apart from Western Australia, the Northern Territory, Queensland and Tasmania, project falls in completion rates (Ogle et al. 2002). Caution is needed when interpreting projections. Comparing university projections for 2001 (Ogle et al. 2001) and completions in pre-registration domestic students (Ogle et al. 2002) shows that universities overestimated by approximately 5 per cent.
Table 2.5 shows a loss of overall load and with it funding for undergraduate non-overseas nursing across the period. Some of the load/funding may have moved to postgraduate courses in nursing but much has been lost from nursing. When the total proportion of funded load is compared, there is very little increase in the postgraduate nursing area compared to the loss in the undergraduate area. Even if the fee-paying load in the postgraduate area is ignored, the total EFTSU load in non-overseas nursing, both postgraduate and undergraduate, decreased by approximately 12 per cent across the period, showing resources have moved out of nursing education since 1994.

Table 2.5 Bachelor degree non-overseas students and load 1994-2000

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<tbody>
<tr>
<td>Commencements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>11 274</td>
<td>11 034</td>
<td>9 920</td>
<td>8 842</td>
<td>8 057</td>
<td>8 652</td>
<td>8 248</td>
</tr>
<tr>
<td>EFTSU Load</td>
<td>8 244</td>
<td>8 018</td>
<td>7 417</td>
<td>6 866</td>
<td>6 957</td>
<td>6 920</td>
<td>6 702</td>
</tr>
<tr>
<td>Completions</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>9 525</td>
<td>9 164</td>
<td>8 104</td>
<td>7 165</td>
<td>6 477</td>
<td>5 844</td>
<td>-</td>
</tr>
<tr>
<td>All Nursing</td>
<td>29 458</td>
<td>27 870</td>
<td>25 887</td>
<td>23 092</td>
<td>23 512</td>
<td>22 961</td>
<td>22 579</td>
</tr>
<tr>
<td>EFTSU</td>
<td>22 050</td>
<td>20 802</td>
<td>19 422</td>
<td>18 516</td>
<td>18 295</td>
<td>18 493</td>
<td>18 491</td>
</tr>
</tbody>
</table>

Source: DEST 2002b

Approximately 30 per cent of undergraduate students come from rural and remote areas (National Review of Nursing Education 2001, Exhibit 6.10). The number of students attending rural campuses grew between 2001 and 2002 in Victoria, New South Wales and Queensland.

Supporting this report is a document, Higher Education Statistics for Nursing Students, which is a rich resource of detailed information on university nursing courses and students (DEST 2002b).

Overseas students

Overseas students make a contribution to the Australian economy as they are usually fee-paying. They provide Australian students with the opportunity to study within a diverse cultural group, and are a potential source of additional nurses for Australia. In 2001 the total load for overseas students doing Bachelor of Nursing degrees was 2323 EFTSU. The majority of the teaching load was for offshore delivery (1345 EFTSU).

According to the Department of Immigration and Multicultural and Indigenous Affairs, some overseas students remain in Australia after completion of their studies. Under a recent immigration announcement, three initiatives to assist entry of nurses were announced. One of these announcements relates to a change in visa requirements to allow all students and their dependents to apply onshore for long stay temporary residence if they have a recognised nursing qualification.

Nursing programs

There has been a great deal of innovation in the types of courses offered and the ways in which they are delivered since the transfer to universities. Universities have attempted to be flexible in the delivery of courses to increase access for students wishing to undertake a nursing degree. Table 2.4 earlier in this chapter provides an overview of the diversity of these programs. Some of the programs listed in the table cater for nurses upgrading from
hospital-based training to a degree, while others are for students beginning nursing education in order to meet requirements for registration.

Undergraduate nursing programs are offered at 29 universities as well as Avondale College. While universities in each State and Territory are most likely to supply new graduates to that particular jurisdiction, this is not always the case. An increasing number of programs is offered by distance mode and universities are sometimes contracted for the delivery of programs to students located in a different State or Territory. Furthermore, new graduates are mobile. Western Australia and the Northern Territory both indicated during consultations that they rely on graduates from New South Wales and Victoria.

Six universities have over 1000 commencing pre-registration domestic students in 2002 (Ogle et al. 2002). In comparison, the University of Melbourne entered the undergraduate nursing market this year, enrolling 19 students in a graduate entry program. In total, full-time or part-time nursing programs are delivered on 59 campuses across Australia, including Geraldton and Whyalla. The location and programs are listed in the report by Ogle and colleagues (2002).

Clinical education

Clinical education for a practice discipline such as nursing is an integral and essential component. While university programs may skill students on particular procedures in laboratory situations, the actual exposure to nursing in its various settings is essential to their understanding of the profession and to the development of competence at the beginning practice level for registration.

Programs offer different lengths and types of clinical experience. Even the total number of hours of clinical experience varies widely both within and between States and Territories. In some cases students are offered elective placements in addition to a core set of experiences. Ogle and team (2002) provide comparative information about the amount of clinical experience and laboratory experience in undergraduate nursing programs. The information compares both States and Territories and the universities within each of the States and Territories where there is more than one university. Most universities require students to spend between 600 and 1100 hours in clinical placements. Laboratory hours varied widely from 50 to over 400 hours (Ogle et al. 2002).

It should not be assumed that the number of hours of clinical experience is an indicator of quality. Ogle and team point out that researchers have challenged the assumption that the quantity of clinical experience correlated with competent nursing graduates (2002).

The involvement of hospitals and other facilities in the clinical education of undergraduate students is examined in a survey commissioned for the Review. Duffield, Donoghue, Uyeda, Mitten-Lewis and Forbes (2001) designed and analysed a questionnaire seeking the experience and views of health and aged care institutions concerning clinical placements for student nurses (enrolled, registered and specialist) as well as transition programs for new graduates. A total of 432 questionnaires were returned with approximately half from metropolitan and half from non-metropolitan areas. While responses were received from all States, none was received from either Territory.

The sample analysed represented four sectors:

- public
- private for-profit
- private not-for-profit
- charitable.
It included acute care (38 per cent), community (4 per cent), day facility (11 per cent), hostel (9 per cent), maternity (6 per cent), mental health (4 per cent), paediatrics (1 per cent), nursing home (26 per cent), and rehabilitation (2 per cent). Public hospitals, a major employer of new graduates, were under-represented in the respondents to the questionnaire. Sixty-four per cent of these organisations offered clinical placements to undergraduates and between 40 and 60 per cent in the other categories accept undergraduate students. If the sample excludes day facilities and hostels and community care, over 80 per cent of health and aged care institutions accept students. Only a small number of day facilities appeared to take students for placements. Some nursing homes provide undergraduate nursing student clinical placements. However, the number is not large.

2.8.2 Transition to practice

Transition to the workplace is a difficult period for new graduates. Clare and colleagues (2002) indicate that transition issues are a constant area of concern in nursing. Of particular concern is how the new graduate is valued and included in the team or unit. Despite this, they found that 77 per cent of the 140 directors of nursing who responded to their survey rated the performance of new graduates as outstanding or good. An even higher proportion of graduates (104 useable responses) rated their experience as a graduate as outstanding or good (91 per cent of these had undertaken a structured graduate program). A similar picture is found in the Nurses Registration Board of New South Wales project to review and examine expectations of beginning registered nurses in the workforce (Nurses Registration Board of NSW 1997). The graduates had high expectations of themselves and assessed that they had adequate professional and clinical competence. Nevertheless, they recognised that they initially required guidance and assistance from experienced registered nurses. This project also indicated that significant numbers of new graduates do not feel competent or are not sure of their competence in areas other than medical/surgical or in locations other than city or regional hospitals.

Not all graduates are able to gain positions in new graduate programs. Duffield and colleagues (2001) report that only 38 per cent from the sample of 432 institutions surveyed provide new graduate programs. The highest proportion of programs is in the public sector where 64 per cent offered these programs. The lowest proportion is in the charitable sector where only 12 per cent had programs for new graduates. For the other two sectors (private for-profit and private not-for-profit), approximately one-quarter to one-third offered graduate programs. Even if a facility has a graduate program there is no guarantee that all new graduates employed there will be offered a place on the program. Clare and team found that in 39 per cent of facilities all new graduates are offered a graduate nurse program (GNP) while in 41 per cent of facilities, less than 20 per cent of new graduates are offered a GNP (2002, p. 112).

The level of satisfaction with new graduates commencing employment varied in Duffield and team's study. The public sector was significantly more satisfied than the private for-profit sector, but generally institutions are 'usually' satisfied with the level of knowledge of new graduates.

Duffield and colleagues also studied the levels of satisfaction with graduates when undertaking specific activities. They compared the results from the first three months of employment and the period between three to twelve months of commencing employment. They found that new graduates showed consistent improvement on all activities. Most sectors showed a mean score of greater than 3, which represents 'usually' satisfied with the level of performance. Time management had the lowest mean score for the initial period.
and continued to have the lowest mean score in the following three to twelve month period except for the charitable institutions where administering level IV medications had a slightly lower mean score in terms of satisfaction with graduates (Duffield et al. 2001).

2.8.3 Practice

In Australia, nurses work in a wide range of environments including the community, prisons, acute hospitals, mental health, child care, doctors’ practices and midwifery, to name a few. Despite this, hospitals continue to employ most of the nursing workforce, so it is not surprising that the majority of graduates begin work in this setting. If the sample in the study of Clare and colleagues is representative of the population of graduates, most graduates (70 per cent) work in public general hospitals, and overall graduates work in large (55 per cent) or medium (37 per cent) sized facilities (Clare et al. 2002, p. 113).

The AIHW (2001d, p. 10) indicates that the proportion of registered nurses working as clinicians in 1997 was 88 per cent. The greatest proportion of these worked in the medical/surgical area (30 per cent) with the next largest group in gerontology/geriatrics (13 per cent). The remainder were spread across a range of other contexts including obstetrics/gynaecology/midwifery (13 per cent), operating theatre (8 per cent) and mental health (7 per cent).

Changes in acute hospitals mean that graduates need higher order skills than previously. Hospitals now have high levels of acuity and patients only stay in hospital for a very short length of time. Staff in acute hospitals also have to contend with the effects of the de-institutionalisation of people with mental health problems and the ageing population. All these factors require staff to have a wide range of skills and expertise.

Of great interest was the need for community knowledge, the sense that nurses need to function within the community with acute skills and with community and ‘social work’ skills in acute settings. Nurses advised that more and more of their focus involves interfaces of care, multiple networks with which they liaise and a greater emphasis on health promotion, healthy lifestyle and disease or injury prevention to facilitate living and health often among an ageing population with increasing chronic disease. Death and grief, however, still colour nursing work where not all nurses are well equipped for this dimension of practice. The shape of nursing, based on the insights from participants, is changing from a hospital based model to needing one of greater seamlessness and collaboration. (Jones & Cheek 2001)

Nursing has also become far more scientifically based, with technological innovations leading to a blurring of diagnostic testing and clinical monitoring. Equipment that was once used for testing is now at the bedside providing continuous data, and nurses are required to be able to use the devices and understand the data they produce. (Aitken et al. 2001).

In addition, new technologies and the rapid expansion in knowledge has led to increasing specialisation among health workers and an expansion of the nursing role. The increasing specialisation resulting from developments in science and technology is well represented by Driscoll in her submission to the Review about critical care specialist nursing:

Workplaces and technology are constantly changing and impacting dramatically upon nursing practice. A prime example is Coronary Care nursing. The advent and explosion of interventional Cardiology has necessitated an urgent need for Coronary Care nurses to revolutionize their nursing practice... There is a high demand for new technology nursing skill acquisition, yet insufficient supply of nurse educators and
clinical support nurses to train the nurses. In today's highly technological healthcare
system, nurses must demonstrate a high level of skills including humanistic and
technological elements incorporating the knowledge and understanding underpinning
the skill.  

(Submission No. 69)

Other implications of the increase of science and technology for nursing include:

• the growing need for understanding of complex ethical and legal issues
• the difficulty of returning to work in highly technologically developed areas of nursing
  after a break from this work
• nurses who become highly technically specialised are also the most vulnerable to being
  overtaken by new technology.

2.9 Specialist nurses

The specialist nurse is difficult to define as there are a number of different perceptions and
interpretations. The more common perception of the specialist nurse is of one who has
developed high levels of specialisation in a clinical area such as critical care nursing.
Another kind of specialist nurse is one who has specialised in nursing a particular group of
clients such as rural and remote nurses, aged care nurses or mental health nurses. All these
nurses have developed the skills and expertise necessary for a particular setting of care or
specific client group.

2.9.1 Education

Specialist education for nurses has largely drifted from hospital-based certificates into
postgraduate programs at universities, although many of these programs are delivered on a
cooperative basis. Unlike undergraduate nursing education, no additional funding was
given to the universities to accommodate this shift. Another important player in this arena,
the New South Wales College of Nursing, offers specialist courses in New South Wales and
some other States and Territories.

Postgraduate courses at university include higher degrees by research, higher degrees by
coursework and other postgraduate qualifications that include postgraduate certificates and
diplomas. Most nursing students are enrolled in higher degrees by coursework (masters level)
or postgraduate certificates and diplomas, because these are the courses that provide for
specialist practice. Higher degrees by research are not relevant to a discussion of the
preparation for specialisation and are discussed in Chapter 7.

Both reports of Ogle and team (2001, 2002) document the level of flexibility in the modes
of delivery of postgraduate courses in universities. There is a wide range of access through
external and mixed (a combination of internal and external) modes of delivery and a high
proportion of postgraduate students are part-time. Universities are also becoming more
flexible by offering an increasing number of courses online. The DEST study of online
education in Australian universities in 2001 found that of a total of 187 fully online
courses offered at postgraduate level 29 were in Health. Online postgraduate Health
courses showed the broadest range of specialisations offered online and the number of
nursing-specific courses was high. Online postgraduate nursing courses include

• Applied Management (Nursing)
• Clinical Nursing Education
• Nursing Practice
While universities are identified as the provider, Duffield and colleagues comment that preparation of specialist practitioners is a feature of many collaborative arrangements between universities and health facilities. From their sample they found approximately 27 per cent of health facilities had agreements with one or more university to provide clinical experience for postgraduate students. Public institutions were the largest group and these provided a broader range of specialisations (Duffield et al. 2001).

**Postgraduate student numbers**
Across the period 1994–2000, the number and load allocated to higher education by coursework (masters degrees) increased from 403 commencing domestic students in 1994 to 820 students in 1999, and then fell to 766 students in 2000 (339 EFTSU) (Table 2.6). There is a similar pattern for domestic commencements in the ‘postgraduate other’ classifications (postgraduate certificates and diplomas); however, the peak occurred one year earlier. There were 2084 commencements in ‘postgraduate other’ courses in 2000 (1190 EFTSU).

Table 2.6 Non-overseas ‘higher degree by coursework’ and ‘postgraduate other’ commencements and completions 1994–2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher degree by coursework Commencements</td>
<td>Number</td>
<td>403</td>
<td>565</td>
<td>605</td>
<td>774</td>
<td>801</td>
<td>820</td>
</tr>
<tr>
<td></td>
<td>EFTSU load</td>
<td>192</td>
<td>259</td>
<td>274</td>
<td>368</td>
<td>349</td>
<td>347</td>
</tr>
<tr>
<td>Complections</td>
<td>Number</td>
<td>119</td>
<td>137</td>
<td>157</td>
<td>203</td>
<td>302</td>
<td>353</td>
</tr>
<tr>
<td>Postgraduate other Commencements</td>
<td>Number</td>
<td>1664</td>
<td>2176</td>
<td>2507</td>
<td>2412</td>
<td>2244</td>
<td>2233</td>
</tr>
<tr>
<td></td>
<td>EFTSU load</td>
<td>889</td>
<td>1156</td>
<td>1398</td>
<td>1373</td>
<td>1285</td>
<td>1277</td>
</tr>
<tr>
<td>Complections</td>
<td>Number</td>
<td>1144</td>
<td>1242</td>
<td>1792</td>
<td>1973</td>
<td>1975</td>
<td>1949</td>
</tr>
</tbody>
</table>

Source: DEST 2002b

Information on specific specialty courses is found in the Ogle and team reports (2001, 2002), which can be accessed on the Review’s website. In 2001 they obtained projections for the numbers likely to complete that year. In 2002, in the second part of the project, they tested the projections made for 2001 with the actual number of graduates. Projections of graduates from the 2001 data proved very unreliable in many cases and were overestimated by about 20 per cent, suggesting postgraduate projections should be treated with caution. In some instances universities overestimated in particular specialist categories.
by 50 per cent. Some States and Territories appear to have difficulty projecting numbers. This may be due to the increasing levels of flexibility in intakes to courses.

Based on their work using broad categories, the number of actual graduates from 2001 is shown in Table 2.7. The greatest numbers of 2001 postgraduate speciality graduates were in the high dependency category (32 per cent), followed by midwifery (20 per cent) and the area labelled generic (11 per cent). The growth projected for 2002 in the high dependency category and in the community health category is of interest (Table 2.7).

Table 2.7 Number of 2001 postgraduate completions compared to projections for 2002 by nursing speciality across Australia

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of graduates from universities (2001)</th>
<th>Number of graduates from NSW College of Nursing (2001)</th>
<th>Percentage of total</th>
<th>Total projected graduates (2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family &amp; Child</td>
<td>167</td>
<td>90</td>
<td>8</td>
<td>175+108</td>
</tr>
<tr>
<td>Midwifery</td>
<td>656</td>
<td>0</td>
<td>20</td>
<td>760</td>
</tr>
<tr>
<td>High dependency</td>
<td>783</td>
<td>290</td>
<td>32</td>
<td>941+515</td>
</tr>
<tr>
<td>Mental Health</td>
<td>216</td>
<td>0</td>
<td>7</td>
<td>280+38</td>
</tr>
<tr>
<td>Aged care</td>
<td>55</td>
<td>22</td>
<td>2</td>
<td>74+36</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>14</td>
<td>0</td>
<td>0.4</td>
<td>14</td>
</tr>
<tr>
<td>Medical/Surgical</td>
<td>168</td>
<td>125</td>
<td>9</td>
<td>221+202</td>
</tr>
<tr>
<td>Indigenous Health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community Health</td>
<td>166</td>
<td>39</td>
<td>6</td>
<td>241+73</td>
</tr>
<tr>
<td>Management</td>
<td>74</td>
<td>20</td>
<td>3</td>
<td>76+55</td>
</tr>
<tr>
<td>Education</td>
<td>38</td>
<td>0</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>Research</td>
<td>60</td>
<td>0</td>
<td>8</td>
<td>108</td>
</tr>
<tr>
<td>Generic</td>
<td>363</td>
<td>0</td>
<td>11</td>
<td>371</td>
</tr>
<tr>
<td>Total</td>
<td>2760</td>
<td>586</td>
<td></td>
<td>3326+1027</td>
</tr>
</tbody>
</table>

Source: Ogle et al. 2002

The ‘high dependency’ area (shown in Table 2.7) has been further broken down in the 2002 project, and this is presented in Table 2.8. At the time of data collection, critical care and perioperative students were the most dominant. The Australian Capital Territory and Tasmania were not recorded in Table 2.8 due to the small number of students in the high dependency area. The Northern Territory has no students in that category in 2002 (Ogle et al. 2002).
Table 2.8 2002 total number of domestic students in high dependency sub-categories for each State and Territory

<table>
<thead>
<tr>
<th>Sub-categories</th>
<th>Vic</th>
<th>NSW</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care</td>
<td>53</td>
<td>63**</td>
<td>71</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Emergency/Trauma</td>
<td>145</td>
<td>89</td>
<td>36</td>
<td>47</td>
<td>12</td>
</tr>
<tr>
<td>High acuity (ward)</td>
<td>14</td>
<td>2*</td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Paediatric crit care</td>
<td>12</td>
<td>18**</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Neuroscience</td>
<td>24</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Critical care</td>
<td>260</td>
<td>244</td>
<td>39</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td>Anaesthetic/Recovery</td>
<td>14</td>
<td>85</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Perioperative</td>
<td>162</td>
<td>155</td>
<td>25</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Cardiac</td>
<td>21</td>
<td>52</td>
<td>17</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive</td>
<td>28</td>
<td>27**</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Ogle et al. 2002
Note: (*) university only, (**) NSW College of Nursing only

2.10 Nurse Practitioner

The National Nursing Organisations (2000) in National Consensus Statement on the Recognition of Nurse Practitioners in Australia define a nurse practitioner as:

... a registered nurse educated to function in an advanced clinical role. The scope of practice of nurse practitioner will be determined by the context in which the nurse practitioner is authorised to practise and will include legislative authority not currently within the scope of practice.

The role of the nurse practitioner has been explored at length within the profession and in recent years a number of States and the Australian Capital Territory have undertaken nurse practitioner projects. All of these projects have made recommendations to protect the title 'nurse practitioner' in some manner to ensure that only nurses who hold an approved educational qualification, and who are registered or authorised as a nurse practitioner, will be able to practise in the role.

Different State jurisdictions in Australia have approached the issue of nurse practitioner to varying degrees, but progress has been slow, partly due to the lack of support from some parts of the medical profession. The list below summarises the situation at the time of writing the report (additional material is at Attachment 2.4).

- New South Wales has progressed further than other States in implementing the role of nurse practitioner. The Nurses Act 1991 (NSW) was amended in late 1999. In October 2001 NSW Health reported that there were nine nurse practitioners authorised by the Nurses Registration Board, and that up to 40 nurse practitioner positions were to be considered for approval (NSW Health 2001a).

- The Australian Capital Territory Nurse Practitioner trial, recently completed, is being evaluated. The project piloted four nurse practitioner service models. The Department of Health and Community Care anticipates that the evaluation will support changes to legislation to protect the title of nurse practitioner (ACT Department of Health and Community Care 2002).

- In Western Australia, the April 2002 Issues Paper for the Nurse Practitioner project (Health Department of Western Australia 2002) advised that legislation required to
enact the nurse practitioner role is in the process of being drafted. In the interim a tender for the provision of appropriate courses had been called.

- In Victoria, the Nurses Board has had, since November 2001, power to endorse eligible nurses for the nurse practitioner role. The Department of Human Services (Department of Human Services [Victoria] 2002) recently called for submissions for sustainable models of practice for nurse practitioners in targeted areas.

- The Nursing Board in South Australia, in September 2001, endorsed the Professional Standards Statement for Nurse Practitioner Practice, including the definition of nurse practitioner and protection of the title. An Information Kit about the nurse practitioner role was released in March 2002 (South Australian Department of Human Services 2002).

### 2.1 Vocational education and training (VET) system

The responsibility for the management and funding of the Vocational Education and Training (VET) system lies with State and Territory Governments and it is through this system that enrolled nurses and trained care assistants are prepared. Although Commonwealth funds support the training sector, its contribution is through the ANTA or through targeted programs administered directly by the Commonwealth (for example, the New Apprenticeships program).

The providers of vocational education and training in Australia include the State and Territory TAFE systems, adult and community education providers, agricultural colleges, the VET operations of some universities, schools, private providers, community organisations, industry skill centres, and commercial and enterprise training providers.

New Apprenticeship training has been designed by industry. The program provides incentives to employers who employ a trainee, as well as personal benefits and support services for the trainee. Some enrolled nurse preparation is undertaken through traineeships and some care assistant training.

Under the VET arrangements, industry training advisory boards (ITABs) are responsible for the national training packages that describe the skills and knowledge required to work in particular occupations. Industry training packages provide the framework for competencies for a particular industry or occupation, through a range of flexible training pathways. The ITAB that controls the areas relevant to nursing work is the Community Services and Health Industry Training Advisory Board.

New Apprenticeships combine paid work with structured training and are ‘competency based’. Group Training Companies employ apprentices and trainees, and then ‘lease’ or place them with ‘host employers’, to complete their training. This arrangement means that businesses can become involved in the training of new apprentices without the commitment of full-time permanent employment. Under this arrangement, the host employer gains apprentices and trainees without providing assurances of long-term employment, and the apprentice or trainee is assured of continuous work and training culminating in a national qualification.

New Apprenticeships offer a new training pathway for enrolled nurses. Under this arrangement there are traineeships in both Victoria and Tasmania. On completion the trainee qualifies with the Certificate IV Health (nursing). As this qualification is recognised as a New Apprenticeship under the National Training Framework, Commonwealth Government support is available to facilitate its implementation.
2.12 Enrolled Nurses

Enrolled nurses work in a range of settings. The AIHW (2001b, p. 11) indicates that the proportion of enrolled nurses working in medical/surgical and in gerontology/geriatrics was about one-third each for 1997. The remainder were spread across a range of other contexts including mental health and operating theatres. Despite the high concentrations in two settings, the recently published ANCI report, An Examination of the Role and Function of the Enrolled Nurse and Revision of Competency Standards (ANCI 2002a), records an extensive variety of places within these settings where enrolled nurses work:

Within the hospital settings enrolled nurses work predominantly in medical and surgical wards, but are also employed in a range of other wards or units, such as cardiology, renal, haemodialysis, intensive care, medical imaging, operating theatre and day surgery, outpatient clinics, geriatric assessment units, palliative care oncology and rehabilitation spinal injury units. Within the aged care setting, enrolled nurses were employed in both high (nursing home) and low care (hostel) areas as well as dementia units and rehabilitation units. (ANCI 2002a, p. 24)

The enrolled nurse is an ‘associate to the registered nurse’. They are included under the various State and Territory Nursing/Nurses Acts. All States and Territories use the title ‘enrolled nurse’ except Victoria, which refers to this level of nurse as Registered Nurse Division Two. According to the ANCI (2002a), the majority of Nurses/Nursing Acts and/or accompanying regulations require that the enrolled nurse be supervised by a registered nurse, and must only undertake lawfully delegated tasks. However, the definition of ‘supervision’ differs between States and Territories as does the length and content of the training for enrolled nurses.

In revising the enrolled nurse competencies, the ANCI included the same domains as the registered nurse competencies but differentiated between the registered nurse and the enrolled nurse roles, competency units, elements and cues (ANCI 2002a p.41). The competency domains are:

- Professional and Ethical Practice
- Critical Thinking and Analysis
- Management of Care
- Enabling.

Currently, enrolled nurse preparation is not included in any of the national training packages, although some training providers give recognition for some Certificates II and III developed by the Community Services and Health Industry Training Board for credit in enrolled nurse training. The inclusion of enrolled nursing in one of these packages would enable the development of articulated pathways between enrolled nursing and other occupations in the health services sector. This is particularly important at this time, as packages for training health technicians are under development at the Certificate IV and Diploma level.

The arrangements for funding enrolled nurse training are more complex than those for undergraduate students since they involve both government and non-government training organisations and different models of preparation. They also vary in the different States and Territories.
2.12.1 Initial education and training—enrolled nurses

Information on enrolled nurse education and training comes mostly from the work by McKenna, Long, Sadler, and Burke (2001), commissioned for the Review. In most cases, the enrolled nurse curriculum is determined through the agreements of TAFE institutes and nurse registering authorities, though there are some private providers in some States.

The development of programs by different providers within the VET sector in the various States and Territories has resulted in considerable variation. In 2001, 22 capital city providers and 32 regional providers offered programs in enrolled nursing.

Although most programs are offered at AQF Certificate IV, Queensland requires a diploma of 18 months duration. The Certificate IV programs are predominantly offered over 12 months full-time study or equivalent, except in Western Australia where the program takes 18 months full-time.

Enrolled nurse student numbers

It is difficult to provide completion data in the VET system as students enrol in modules rather than courses. As a result only numbers of commencing student enrolled nurses are shown here. Since 1997 the numbers of commencing student enrolled nurses have increased according to National Centre for Vocational Education Research (NCVER) from 3688 to 6090 (Table 2.9). This is not the trend in all States. Western Australian numbers show considerable variation between years as do those of New South Wales and Queensland, but to a lesser extent. TAFE institutions reported that competition for places in enrolled nurse courses is high.

Table 2.9 Enrolled nurse commencements by State and Territory

<table>
<thead>
<tr>
<th>Year</th>
<th>Australia-wide</th>
<th>New South Wales</th>
<th>Victoria</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Western Australia</th>
<th>Tasmania</th>
<th>Northern Territory</th>
<th>Australian Capital Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>3688</td>
<td>1311</td>
<td>1816</td>
<td>225</td>
<td>0</td>
<td>295</td>
<td>0</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>1998</td>
<td>3789</td>
<td>1290</td>
<td>1892</td>
<td>243</td>
<td>149</td>
<td>175</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>1999</td>
<td>4641</td>
<td>2245</td>
<td>1785</td>
<td>199</td>
<td>153</td>
<td>223</td>
<td>0</td>
<td>0</td>
<td>36</td>
</tr>
<tr>
<td>2000</td>
<td>4650</td>
<td>1775</td>
<td>1928</td>
<td>355</td>
<td>366</td>
<td>166</td>
<td>0</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>2001</td>
<td>6090</td>
<td>1530</td>
<td>3190</td>
<td>400</td>
<td>620</td>
<td>220</td>
<td>0</td>
<td>0</td>
<td>140</td>
</tr>
</tbody>
</table>

Source: Data supplied by NCVER 2002 (unpublished). The NCVER suggests that we treat commencements data with caution.

Programs

The flexibility of programs varies considerably around Australia. In New South Wales all students undertake a full-time employment model. In 2001 there was no option available for part-time studies in that State. Western Australia also offered only full-time programs. Within the other States and Territories, there is greater flexibility for students to study either full-time or part-time.

As well as TAFE institutions, there are a number of private training organisations that deliver enrolled nurse training. Some of these use traineeships as the mode of delivery. The Royal Adelaide Hospital in South Australia, for example, is an accredited private training organisation delivering enrolled nurse training through a hospital-based program.
Many TAFE institutes are considering means for improving the flexibility of program delivery. As highlighted by a number of rural institutes, many students travel large distances to and from scheduled classes. Some institutes in South Australia and Queensland offer many modules by distance education. Teaching and learning is supported through the use of videoconferencing facilities in outlying areas, reducing the need for students to travel long distances. Spencer Institute in South Australia also offers a Certificate IV program across State borders for students in other States including Tasmania and Queensland. Some Queensland students travel to South Australia to undertake clinical experience.

Clinical training
The study by Duffield and team shows that, in contrast to the student registered nurses, student enrolled nurses were more likely to gain clinical training in the private and charitable category than in public institutions (2001 p. 36). This is not surprising since it is likely that a significant amount of that training is focused on the aged care sector. The employment status of enrolled nurses varied in relation to institutional profiles. Seventy-eight per cent of institutions in the public category indicated that the students were supernumerary and most of the remainder counted them as full-time staff. A similar profile exists in the private for-profit category of institution.

Enrolled nurse students usually undertake block placements in health and community settings throughout their programs. The focus for clinical practice experiences varies between States and Territories, but they all include significant amounts of aged care and rehabilitation experience. Increasingly however, programs are reducing their emphasis on aged care and rehabilitation. All the programs included in the McKay study (2001) provided students with exposure to acute care areas, mainly medical/surgical nursing. From the interviews it appears that more attention is being placed on acute care nationally than was previously the case. Many programs have introduced placements within mental health and community care, including such areas as outpatient clinics and maternal child health. Within a smaller number of institutions, students are also being exposed to clinical areas such as maternity, paediatrics, operating theatre and, in one case interviewed by the study, even emergency. This exposure is opening up new practice possibilities for enrolled nurses on completion of their programs.

2.12.2 Transition to practice
There are few transition programs for enrolled nurses. The study by Duffield and team shows that supervising nurses reported that new enrolled nurse graduates have problems with time management and documentation at three months but generally the scores for satisfaction are above 2 (occasionally satisfied) (2001). The emphasis on documentation in the charitable and not-for-profit institutions represents the interests of aged care in these two types of institutions.

2.13 Trained care assistants
While there is an expanding body of literature on nursing skill mix, particularly in the United States and Canada (Crisp 2001), there appears to be little attention in the literature to the role of trained care assistants (by whatever name). This is an area the Review also overlooked in commissioning its research.
2.13.1 Training for care assistants
The Community Services and Health Industry Training Advisory Body has developed two training packages that accommodate occupations and skills in related fields of health. The Community Services Training Package, which is being reviewed, currently encompasses three relevant occupations in the fields of Aged Care Work, Community Work and Disability Work. The specific Certificates that have direct relevance to people wishing to become trained care assistants are the Certificate III in Aged Care, Certificate III in Community Care and Certificate III in Disability Work. Other areas with relevance to nursing work are the Certificate IV Community Services (Service Coordination) and the Advanced Diploma of Disability Work.

The Health Training Package was endorsed in December 2001. The package contains qualifications from Certificate II to Advanced Diploma in areas of general health service delivery, ambulance, dental technology and prosthetics, dental assisting, and complementary and alternative health care. The addition of the technical health workers sector to the Health Training Package is due to be completed in 2002. While qualifications at Certificate II and III level do not encompass nurses, they do prepare a range of workers whose work is often done under the supervision of a nurse. This is particularly true in aged care.

Schools in some States and Territories have begun to introduce students to care work through the senior school curriculum via these VET programs. These courses may be at Certificate II level and can articulate into Certificate III, which should be the minimum entry for trained care assistants.

A range of models in education and training showing the pathway from the Certificate III trained care assistant to the nursing doctorate are shown in Table 2.4 (earlier in this chapter). These models include traineeships involving paid work and structured training, which can be on-the-job, off-the-job or a combination of both. On-the-job training is also possible under the New Apprenticeships program.

Numbers in training
Table 2.10 shows the number of people commencing training for 1999 to 2001 from the Community Services Training Package, which has only been in operation since February 1999. The Health Training Package is even more recent and therefore there are no commencements for these two years.

Although newly introduced, the uptake of the Certificate III qualification in Community Services (Aged Care Work) has risen significantly over the three years from 1136 enrolments nationally in 1999 to 17 048 in 2001. Between 1999 and 2001, States where growth compared to size has been most rapid are South Australia, from 3 to 2473 enrolments and Victoria where the growth was from 279 enrolments to 5915 (See Tables 2.10 and 8.1). During consultations in South Australia, we heard that up to 80 per cent of unregulated workers in the aged care sector had achieved Certificate III qualifications under the Community Services Training Package due to the ‘strong leadership of the South Australian Directors of Nursing’ working in the aged care sector.

There is also an increase in the number of people starting the Certificate IV in Community Services (Aged Care Work). In the same period, 1999–2001, the number of commencements in this course increased from 67 to 2308 nationally, with Queensland showing the most significant increase at the State level. Although not to the same extent as that of Certificate III in the Aged Care Work, growth occurred in commencements in Certificate III in Community Work and also Disability Work.
Table 2.10 Vocational course enrolments in specific Community Services Training Packages across Australia for 1999–2001

<table>
<thead>
<tr>
<th>Community Services Training Package Qualifications</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate III in Community Services (Aged Care Work)</td>
<td>1 136</td>
<td>10 278</td>
<td>17 048</td>
</tr>
<tr>
<td>Certificate IV in Community Services (Aged Care Work)</td>
<td>67</td>
<td>1 212</td>
<td>2 308</td>
</tr>
<tr>
<td>Diploma of Community Services (Aged Care Work)</td>
<td>0</td>
<td>73</td>
<td>135</td>
</tr>
<tr>
<td>Advanced Diploma of Community Services (Aged Care Work)</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Community Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate III in Community Services (Community Work)</td>
<td>162</td>
<td>1 955</td>
<td>2 474</td>
</tr>
<tr>
<td>Certificate IV in Community Services (Community Work)</td>
<td>53</td>
<td>1 770</td>
<td>2 323</td>
</tr>
<tr>
<td>Diploma of Community Services (Community Work)</td>
<td>18</td>
<td>1 364</td>
<td>2 306</td>
</tr>
<tr>
<td>Advanced Diploma of Community Services (Community Work)</td>
<td>6</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Disability Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate III in Community Services (Disability Work)</td>
<td>162</td>
<td>2 110</td>
<td>3 224</td>
</tr>
<tr>
<td>Certificate IV in Community Services (Disability Work)</td>
<td>39</td>
<td>1 575</td>
<td>2 808</td>
</tr>
<tr>
<td>Diploma of Community Services (Disability Work)</td>
<td>1</td>
<td>71</td>
<td>191</td>
</tr>
<tr>
<td>Advanced Diploma of Community Services (Disability Work)</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Data supplied by NCVER 2002 (unpublished)

2.14 Working relationships

Positive working relationships are important to patient care and involve a wide range of workers and professionals with different levels of skills. Jones and Cheek (2001), in summarising the views of the nurses they interviewed, put the case this way:

Strengths and positive gains for consumers were felt to occur when nurses were able to collaborate with others, to be recognized as part of a team with equal input. Many nurses gave examples of flexible working structures that see the nurse based in a number of venues with a diverse client group perhaps community based yet have acute facility input. In these examples nurses have developed ways of working positively with other health professionals and at times take on a strong leadership role. Nurses also work in teams with unregulated workers such as PCAs or AIN’s who provide continuity with the patient and support for a nursing role. In community health centres, the prison setting or emergency department in rural areas nurses work with greater degrees of autonomy, although they may not be recognized for such independent practice.

The relationships between registered nurses and enrolled nurses are usually based on direct supervision and delegation. However, there appears to be considerable ambiguity about what the role of the enrolled nurses should be. As the associate nurse, Jones and Cheek (2001) found that enrolled nurses often regarded their practice as very similar to that of a registered nurse, except for the areas of paperwork and medication. In some settings enrolled nurses had greater input into both these aspects of the registered nurse role. Nevertheless, the enrolled nurses in the study were concerned about the apparent inconsistency, on an almost daily basis, in what they were allowed or expected to do. They argued that variation in expectations and role function occurred between wards or units within an institution and even between registered nurses on the same shift.
2.15 Legal and regulatory environment

Broad policy frameworks, as well as specific legislation and regulation, affect nursing. One policy, the National Competition Policy, has resulted in a review of current State and Territory legislation, including that covering health workers.

Australian governments agreed that legislation should not restrict competition unless it could be shown that the benefits of the restriction to the community as a whole outweigh the costs, and the objectives of the legislation can be achieved only by restricting competition. Over 1700 pieces of legislation were identified by governments for review, extending across a range of industries and sectors. As part of the process, the Nurses/Nursing Acts for all States and Territories have been, or are being, reviewed as part of this process. The Legislation Review Program was most interested in restrictions on entry, registration, title, practice, advertising and disciplinary provisions of the different Nurses/Nursing Acts. To date the review has been completed in all States and Territories, with the exception of Queensland and Western Australia. In some States and Territories new or amended legislation has eventuated from the review. Some States are still considering the final report from the review in their State, with the restrictions that were the subject of the review being explored differently in the various jurisdictions.

The appropriateness of applying National Competition Policy to health sector legislation, and in particular to nursing, has been questioned. The Queensland Nursing Union's submission to the Legislation Review Program set out its concerns, stating that the regulation of nursing can be justified to protect the health of the community. The submission drew attention to the fact that nurses do not set their own fees, onerous limitations on entry are not placed for speciality practice, and nurses cannot be accused of supplier-induced demand. The report states 'We also believe that the objective of the Nursing Act 1992, "to make provision for ensuring safe and competent nursing practice" can only be achieved by "restricting competition". That is, the safety of the community can only be assured by regulating nursing practice and those who can undertake it'.

(Queensland Nurses' Union 2001).

2.15.1 Nursing legislation and regulation

In Australia, nursing registration boards in each State or Territory established under a State or Territory Act decide whether a person has the qualifications and experience to allow them to be registered as a nurse.

The State and Territory nurse registration boards come together in the ANCI, which aims to lead a national approach in evolving standards for statutory nurse regulation. All boards have agreed that new nurses must meet the ANCI Competencies (ANCI 2002a) for registration. The boards also accredit nursing preparation courses to ensure they enable students to meet these competencies. Some of the boards also accredit the institutions that deliver nursing courses.

Mutual recognition

To overcome the constraints posed by differing regulatory arrangements for nursing across jurisdictions in Australia, the States and Territories agreed to introduce mutual recognition legislation. As outlined in Selected Review of Nurse Regulation (Chiarella 2001), mutual recognition agreements between different States and Territories, or even countries, mean that nurses who are registered to practise in one jurisdiction can apply for registration in participating jurisdictions with a minimum of documentation. In Australia, the relevant legislation is the Mutual Recognition (Commonwealth) Act 1992.
Mutual recognition arrangements came into being in May 1992 when premiers and chief ministers of Australian States and Territories signed the Intergovernmental Agreement on Mutual Recognition committing jurisdictions to implement mutual recognition from 1 March 1993. The Commonwealth legislation used to implement the Agreement is the Mutual Recognition (Commonwealth) Act, which commenced on 1 March 1993, with all States and Territories subsequently passing legislation to join the scheme. Under the Trans Tasman Mutual Recognition (Commonwealth) Act 1997, mutual recognition was extended to New Zealand.

Mutual recognition has streamlined the process of registration for those nurses who wish to move between jurisdictions. This means nurses and midwives registered in one State or Territory can apply with ease for registration in another jurisdiction.

While mutual recognition has simplified many of the operational matters for nurses wishing to move between States and Territories, there are differences in approach between the jurisdictions that create tensions. One of these areas is the requirement for recency of practice or evidence of continuing competence. New South Wales is the only State without such a requirement for continuing registration (Chiarella 2001). Another area of difference is the approach to decisions on the scope of practice of enrolled nurses and registered nurses, particularly in the treatment of issues such as delegation, though these may be more directly influenced by State and Territory factors other than the Nurses/Nursing Acts. In addition, mental health nursing is treated differently across the jurisdictions.

Mental health nurses
In the past, nurses who had completed a direct entry mental health program (psychiatric nurse education program) were placed on a register kept for this purpose. In recent times many of the States and Territories have revised their respective nurses Acts and the names of all nurses are now placed on a single register. Nurses with mental health qualifications are registered on the same register as all other nurses. In South Australia, to work as a mental health nurse, a nurse must be registered as a mental health nurse or be supervised by a Registered Mental Health Nurse. In some jurisdictions direct entry mental health nurses are registered on the single register and are authorised to practise in mental health only, for example Western Australia. This authorisation is noted on their practicing certificate/licence to practise. In most jurisdictions nurses who hold current registration can work in the mental health area whether or not they hold mental health qualifications.

Midwives
In all States and Territories, to work as a midwife a person must hold current registration as a midwife or be authorised or endorsed to work as a midwife.

Other countries that consider midwifery to be a distinct discipline from nursing either regulate it in a separate statute or make specific provisions for midwives as distinct from nurses (Chiarella 2001). In the light of the introduction of direct entry midwifery courses in some Australian universities in 2002, the legislation in at least one jurisdiction has had to be revised.

Extending regulation
One of the challenges for this Review is to find the best way to protect the public while using the appropriate range of workers to do "nursing work" in its broadest sense. The question of the regulation of all workers involved in nursing work, either by title or by area of work, is one that has had considerable debate. As new workers enter the health,
community and aged care areas, the issue of regulation arises. To introduce regulation for a new group of workers the case for public protection needs to outweigh the restrictions on competition. This is a particular issue when considering the growth of care workers such as personal care assistants, assistants in nursing and aged personal carers.

Summary of regulatory issues
Despite the different types of national policy agreements, much of the legislation and regulation in areas covering health is State or Territory based, due to the division of constitutional responsibilities. This includes the legislation and regulation related to doctors and nurses, as well as a range of legislation that affects their work. These arrangements have implications for the consistency of nursing education and the concept of supervision, particularly for enrolled nurses, which is discussed in more detail in Chapter 5.
3 Australian nursing—the future

In the future, there will be continuing changes in the way health care and education are delivered, changes in the expectations of people receiving the services of workers within these sectors, and changes in the expectations of the workers themselves. Consequently, it is not possible to set detailed guidelines for the way nursing education should be planned for the future. What we can do is develop a decision making framework and vision for nursing that will assist in the development of nursing education, to ensure that nursing can meet the needs of future generations.

This chapter provides a framework for immediate decisions and for the development of nursing education and the practice of nursing. It incorporates a view of nursing that is inclusive in its practice and the values it endorses. It assumes a perspective on care that is person-centred and that promotes the dignity of the person. The advancement of nursing requires nurses to be knowledge workers who act in highly professional ways towards all those who form part of health, community and aged care teams and towards those for whom health outcomes are pursued. This role will be carried out in a whole-of-health context, one that incorporates the community and institutional care settings, and education and research settings.

3.1 Vision and values—education and health policy

Health care and education are essential to the maintenance and development of the Australian community. While much of the debate at present is about resources, the values the Australian community espouses and the decisions that flow from these values, filtered through democratic processes, determine future Australian systems. Resource allocation is always a matter of values, whether these are made explicit or not. At the ICN Conference, Maynard (2001) proposed that there are three healthcare policy goals:

• the control of expenditure
• efficiency
• equity.

Efficiency always involves some form of rationing system and equity can be taken to mean either the geographic distribution of healthcare resources or the access for all to those resources regardless of their ability to pay. How these policy goals are actioned depends on the value system applied.

3.1.1 Health policy

Of interest in looking towards the way Australia will address health policy in the future is the work being undertaken in Canada, a country very similar to Australia in the system of government and attitudes to social policy. Romanow (2002), in the interim report of the Commission for the Future of Health Care in Canada, begins with a discussion of the importance of values and the role they play in defining the issues facing health care. It is an important discussion because it demonstrates the influence of the value system of individuals and communities on issues as diverse as:

• where and how individuals and governments spend the healthcare dollar
• the role of private versus public in service delivery
• decisions on how disparities in health outcomes and status are addressed
the roles, rights and responsibilities of individuals in terms of their own healthcare
views on the way the healthcare system should be structured
the criteria used to assess the performance of the healthcare system and those delivering
the services.

From his initial consultations, Romanow identifies four positions on resolving current
difficulties and planning for the future, each underpinned by a set of values (2002,
pp. 11–12).

Some people advocate more public investment through additional resources, to be paid by
either increasing taxes or reallocating funds from other government programs. Others argue
for more resources but through a greater sharing of the costs and responsibilities by means
of options like co-payments, user fees, taxable benefits or private insurance. For both of
these positions the role of governments is central to the allocation of services.

A third perspective is that market discipline will improve the system’s effectiveness,
efficiency, productivity and consumer satisfaction. Advocates for this perspective argue for
greater choice through both the public and private health sectors. Another view is that
more cost-effective outcomes and consumer satisfaction can be achieved through re-
organising service delivery to provide a seamless system.

Canada, like Australia, has a national insurance scheme to provide universal public
coverage. The scheme is based on five principles made explicit in the Canada Health Act:
• public administration
• comprehensiveness
• universality
• portability
• accessibility.

Part of the role of the Canadian Commission is to interpret these principles as the
demands on the system increase and attitudes change.

Similarly, Australia’s Medicare scheme structures much of the delivery of health care in
Australia. It was developed in the 1980s to meet three objectives:
• To make health care affordable for all Australians
• To give all Australians access to health care services with priority according to clinical
  need, and
• To provide a high quality of care.
  (HIC 2002)

The current healthcare system in Australia is shaped to a large degree by the way Medicare
functions. The question of the capacity of Medicare to provide a sustainable system for the
future is fuelling debate and some shifts in policy. Changes to the funding of health care will
impact directly on the health professions and their relationships. Changes in community
attitudes will be reflected in the roles governments take in relation to health care.

3.1.2 Education policy

As with Medicare, the broad objectives for Australian higher education display a
commitment to the individual, but also to economic and social outcomes.

The main purposes of Australian higher education are to:
• inspire and enable individuals to develop their capabilities to the highest potential;
• enable individuals to learn throughout their lives (for personal growth and
  fulfilment, for effective participation in the workforce and for constructive
  contributions to society);
advance knowledge and understanding;
• aid the application of knowledge and understanding to the benefit of the economy and society;
• enable individuals to adapt and learn, consistent with the needs of an adaptable knowledge-based economy at local, regional and national levels and
• contribute to a democratic, civilised society and promote the tolerance and debate that underpins it.

(Nelson 2002, pp. 1–2)

Like the health system, the education system is also influenced by shifts in resources and attitudes, some of which are currently being tested and debated with the review of higher education. The outcome of this review will also affect the future preparation of health professionals. While these are localised debates they have much in common with what is occurring in other comparable countries.

### 3.2 Expectation of change

Australia is not isolated in dealing with change. Global trends impact through policy debate, global comparisons, shared knowledge and the interchange of people, goods and diseases. Conflicts and economic relationships directly affect the economy and security of Australia. The global climate in which education and health outcomes for Australians will be addressed is likely to increase in complexity. The role of education is not only a professional issue, but also one with more encompassing concerns including those of supply of the labour market, ethical and social considerations and knowledge distribution. Efforts to predict what will be needed in particular sets of skills or supply in any industry will be undoubtedly wrong. What is possible is to establish the qualities and structures that offer the best potential for meeting the demands for care as they occur in the future in a fair and responsible manner.

The importance of education in meeting constant change is explained in the DeSeCo Symposium Discussion Paper (Rychen & Salganik 2002, p. 3):

Societies all over the world are facing rapid social and technological changes. While increasing uniformity through economic and cultural globalization is one characteristic of today’s world, another is the growing diversity, competition, and liberalization both within and among different societies. Governments and societies seek economic growth— but are also increasingly concerned about its impact on the natural and social environments (OECD 2001). Large-scale value changes, instability of hitherto accepted norms, substantial global inequality of opportunities, social exclusion, poverty in all its forms and environmental threats are some of the most significant challenges. It is in this context of an interdependent, complex, and conflict-prone world that education is becoming increasingly crucial as an investment and an important asset for both individuals and societies. Sustainable economic development, social welfare, cohesion and justice, as well as personal well-being, are closely bound to human and social capital.

The Symposium Discussion Paper attempts to draw together the conceptual and theoretical work on the key competencies needed to achieve a quality of life and human wellbeing in order to provide a broad framework for education and training. Education and training will occur through the formal institutions of learning or through informal processes. Underpinning much of the discussion is that of change and complexity in the way we work, live and play and the attempt to identify those competencies that allow...
individuals and society to deal successfully with change and to set new directions. It is an attempt to find a framework for education and training that gives the underpinning for lifelong learning.

### 3.3 New ways of thinking—seeking synergy

A common theme of managing change and the development for individuals and organisations in this information-rich age is that of drawing together the diverse sources of information and expertise. This is found in concepts like:

- **lifelong learning**
- **integrating theory and practice**
- **team approaches to health care**
- **whole-of-health perspectives in planning services**
- **responsiveness to the context in which work occurs, rather than a focus on regulation and boundaries.**

#### 3.3.1 Lifelong learning

There is broad acceptance that underpinning a successful approach to life is the development of critical thinking and reflective practice. This approach assumes an evolutionary model of human development where individuals advance so that they are able to incorporate higher levels of complexity into their thinking and actions (Kegan 2002). This concept is well known from the work of men like Kohlberg and Piaget. However, Kegan’s research (2002) moves the thinking beyond the years of childhood and early adulthood. It contends that development needs to continue throughout adulthood by building on what has been achieved from the various stages of formal education. This type of thinking implies that to address a world of rapid change lifelong learning will be necessary for individual success, as well as economic development and social cohesion. To achieve these outcomes, education should be 'not merely for the acquisition of skills or an increase in one's fund of knowledge, but education for development, education for transformation' (Kegan 2002).

#### 3.3.2 Learning and practice

There have also been significant developments in the way we think about ‘learning’ and its relationship to ‘practice’. Gonzi (2002) identifies these, along with other developments in neuroscience and the cognitive sciences and new concepts of knowledge and knowledge management, as influencing the need for change in the way educators approach learning for practice. Moreover, he suggests that new philosophical arguments are also leading to the convergence of these intellectual areas of activity and the insights they provide for education and training. These developments challenge educators to examine how to best prepare professionals to meet the challenges of practice now and in the future. Professionals will be required to embrace change in the way they work, manage changes in social values and consider the implications of shifts in economic policy.

#### 3.3.3 Whole-of-health perspective

There are many different ways to address the health of the population and plan the services to assist in health promotion and care. In Australia, we tend to separate our considerations of community, aged and health care in the way we fund and report the services. While this may be useful for the purposes of management, it creates many other discontinuities.
Much of the current debate about health care assumes that the best way to develop delivery systems is to have an ‘integrated’ approach focusing on the needs of the consumer. A typical example of this approach is found in the Western Australian Government document, Health 2020: A Plan for Metropolitan Perth, which describes that State’s goals for an integrated health system (Health Department of Western Australia 2000a). Interestingly, this is also the view the new National Health System (NHS) in the United Kingdom has taken by funding primary care as the purchaser of other services including hospital services. These types of developments are being described as primary care led services and integrated care pathways (Cochrane et al. 1999).

Australia has no infrastructure capable of providing this framework at present; however, recent moves to establish a national strategic health workforce body will, if successful, begin a more systematic integrated planning process across the different health and medical professions.

The expectations emerging from integrated service models will define how ‘nursing’ is expected to respond to new demands from the labour market. This debate, the assumptions behind it and evolving systems of work practice will influence decisions about the best approach to the future education and training of nurses. In the longer term, questions about how best to address the particular education and training needs of nurses will need to be considered in a complex web of relationships of the whole spectrum of other health workers and professions. The relative roles of the general practitioner, nurses, allied health workers and trained care assistants involved in primary care will affect education requirements. For those who work in hospitals, the way medical clinicians, technicians, nurses and allied health professionals relate will influence the design of education.

### 3.3.4 Relationship to context

Trends in models of care are becoming more context-based, with networks between these contexts. There are high levels of specialisation developing in narrow technical or scientific areas related to specific diseases or conditions (for example, diabetes control). High levels of expertise often need to be mediated to the patient by links to centres where the specialisation resides. New ways for mediation to occur are possible with changes in technology such as telemedicine and telehealth. Hospitals also have outreach services to work with patients and are linked to clinics or centres that provide a specific service such as birthing centres.

Related to these developments, there is evidence of role considerations in relation to different settings of care. One role consideration is the trend to specialisation and sub-specialisation. In Australia, evidence for this is the drive to establish midwifery as a profession separate from, but related to, nursing, and the developments in defining national competencies for a range of healthcare technicians. Another approach is that of teams of professionals working in a way that reduces professional boundaries, and the development of roles and new practitioners (Cochrane et al. 1999). Healthcare teams do not preclude the increasing specialisation since some of these developments are in the area of technicians, a rapidly growing occupational group with narrow specialisations. Healthcare teams are also important in areas of care like small rural communities, where clinicians require a broader level of advanced competencies due to the service they provide.
3.4 Nurses—the ‘wide-ranging’ healthcare practitioners

To date, nursing has negotiated its path through these different responses to care needs. It has offered opportunities for high levels of specialisation in clinical areas in acute settings and also provided more general services that range as broadly as that of ‘bush nurse’, practice nurse in a doctor’s surgery, to those who work in the flying doctors service and prisons. The development of nurse practitioner roles has been slow and there is already a view that this role is outdated even as it is being developed. Whether nursing will continue to diverge from a common base of education and training in all the directions it currently embraces will be answered in part by the evolution of care systems in Australia and the decisions of nurses as a professional group.

3.4.1 Care in the community

Combined with scientific advances, some shifts in the philosophy underpinning healthcare policy have resulted in more emphasis on customer service through the integration of services within the community. In Australia this is reflected in a decrease in the percentage of recurrent health expenditure on hospitals (see Table A1.1.1 in Attachment 1.1) and a decline in employment in all hospitals of almost 8 per cent between 1986 and 1996 to 222 423 and an increase in employment in other health industry settings of 52 per cent to 306 366 (AIHW 2001a). However, the evidence to support a substantial shift of nursing resources to the community sector is not easy to find.

Aitken and colleagues (2001) describe this trend as a move away from institutionalised care towards relocating care closer to clients in their homes or local communities. They indicate that the literature shows new ways of delivering care including case management/managed care, patient-focused care, community nurse-led care, integrated hospital and community care, family provided care and care delivered by unlicensed personnel (these are discussed in more detail in Chapter 4). They point out that these changes have affected all care modalities, but the literature also reveals specific considerations in the areas of mental health, acute care and midwifery.

The influence of a shift away from institutionalisation will demand a cost-effective mix of skills and workers. Nursing currently has an essential role, which will expand and change; however, the use of all levels of care worker will be required to sustain a system that promotes ‘care in place’. Nurses are in an excellent position to design and influence these care systems.

3.4.2 Integrated nursing workforce

The demands for nursing care in all the different care settings will require systems and thinking that bring together all nurses with their differing expertise and those who support their work directly. The nursing workforce includes trained care assistants, enrolled nurses, registered nurses, nurse managers, nurse educators and researchers, and nurse practitioners. Many nurses will work in nursing teams and cross-professional teams, others will work more independently but be reliant on their networks of nurses and health professionals.

In developing the nursing workforce of the future, employers may need to provide incentives for nurses and trained care assistants to make transitions between the various levels of the workforce and into areas requiring different skills as part of planning strategies. There is already some evidence of informal arrangements and even some formal arrangements with some employers to encourage nurses and trained care assistants to advance in their careers. While not perfect, the systems are in place to allow this to occur.
3.4.3 The place of nursing in care systems

Nursing has a particular place in health, aged and community care since it fills a complex mix of roles incorporating functions as diverse as 'care giver; patient advocate (negotiator/mediator); educator; co-ordinator; integrator; manager; counsellor; agent of change and ethicist' (Marles 1988).

In an environment that becomes more technical and specialised, the potential for nursing to draw these elements together to provide a patient-centred service is its strength. One respondent to the Study of Professional Issues in Nursing in Victoria (Marles 1988) stated, that the importance of the role of nurses was not only related to treatment but also to assisting people in decision making since 'many decisions about which course of treatment to follow, are not so much medical decisions but personal decisions that should be made by the patient and/or his or her family' (S155 p. 166–186).

Two submissions to the same study demonstrate the role of the nurses as drawing together a focus on the person and providing a different perspective on what constitutes care. Both examples are from the acute hospital context where 'care' is structured around 'medical care' and is concerned largely with disease diagnosis and cure. In these environments nurses observe that their contribution is often underestimated. In articulating this contribution, the two submissions highlight the social importance of the role of the nurse:

The unique position of the nurse in the health care system ... enhances the nurse's ability to develop an interactive/interpersonal therapeutic relationship that permits her/him to gain knowledge of the whole person and the ways in which each person defines their experience of illness. It is this 'insight', this knowledge, along with the nurse's theoretical knowledge of disease and her/his therapeutic skills that provides the basis for the humanisation and 'holistic' nursing approach to patient care.
(Marles 1988, S28 p. 26)

The nurse needs to be courageous enough to speak out when there appears to be conflicting interests between patients and medical staff.
(Marles 1988, S92 p. 165)

3.4.4 Inclusive practice

One of the distinctive features of nursing is that, although the community recognises the unique identity of nurses and their importance to health and wellbeing, many people other than nurses care for those unable to care for themselves. The practice of nursing essentially involves promoting health outcomes through the integration and balancing of care and cure. Essential to the role is enabling others, where needed, to carry on this role when the nurse is not there—for example, when the patient returns home from hospital. Often this occurs when the balance shifts from a focus on cure to one more directed to care and support. This facilitative role is likely to become even more important with the ageing of the population, the ease of access to information, the range of available medications, alternative health therapies, and the highly technical nature of many medical interventions. Chiarella explains the nature of inclusive practice in the following quote taken from a more extensive piece in the Review's Discussion Paper (Exhibit 3.3):

In reality, nursing work has always involved teaching others to care for the sick, as well as caring for the sick themselves. Nursing care has never been carried out exclusively by nurses. Many unqualified carers, usually women, care for their sick families, both young and old, and nurses working in both hospitals and the community have given support and education to such familial carers over the years. In this way, nursing, unlike many other professions, has been an inclusive, rather than an exclusive, discipline.
Some nurses have seen this as highly problematic, as it is well-nigh impossible to exercise any monopoly over most aspects of caring activities. Life would be very difficult for many families if lay persons were not involved in caring for their sick. This phenomenon will only increase with longer length of stay and early discharge. In addition, other health care professionals also regularly demonstrate their commitment to caring, as well as curing activities. Because of this inclusive nature of nursing practice, it has also been difficult to proscribe nursing or caring activities by legislation, as other disciplines have been able to quarantine certain aspects of their work...

(National Review of Nursing Education 2001, p. 41)

3.5 Framework for developments

These trends in health, community and aged care and their relationship with nursing practice form the basis of the framework presented in the following section. This framework offers a way to think about, plan for and respond to the changes that will continue to occur in care systems and, consequently, in nursing.

The framework examines the need to:

- value and develop intellectual capacity in the education and care sectors
- build partnerships
- develop systems that promote individual advancement and progression
- develop systems that are flexible
- encourage diversity
- facilitate access for the disadvantaged
- use technology wisely and creatively.

3.5.1 Nurses: Knowledge workers in knowledge dependent organisations

Drucker (2001) talks about nurses as knowledge workers. He lists nursing as the second new knowledge profession, a profession which is now working with old high knowledge professions such as medicine and a recent but expanding group of new professionals, medical technologists. The latter group is a response to the rapid increase in diverse specialisations. In turn, this development is due to the rapid obsolescence of knowledge and the need to link this new knowledge with hands-on tasks.

The drive to specialisation, which is also affecting nursing, could result in a health system that is highly fragmented and driven by technical expertise, rather than one focused on the needs of the patient in terms of care and cure. Nursing has the capacity to bring together those two aspects in a wide range of settings including acute, community, long-term aged care and public health. Due to the respect of the public, nurses also have an advantaged position to take on the role of the 'knowledge broker' (Stilwell 2002) between informed clients/patients and other health professions whose focus is on medical intervention or behaviour change.

3.5.2 Valuing and developing intellectual capacity

As professionals respond to the demands of new knowledge and technology, employers will need to rethink the value of the intellectual capital they have available to them. The investment required to build the levels of expertise that are now available to organisations such as hospitals has been considerable. Although this expertise and knowledge are
somewhat 'intangible', the identification of these resources is beginning to feature in the literature on performance drivers. While it may be unusual to consider service industries such as health care and education in this way, the investments in health and education mean these are large industries with high levels of intellectual capital. To achieve the best outcomes from this investment, identifying and maximising these performance drivers is essential.

Ferrier and McKenzie (2002) suggest that the shift to new performance drivers is promoting a new set of questions in organisations interested in maximising their performance. These questions are:

• What are our sources of value?
• Are we using them wisely?
• How can we tell?
• How do we tell our partners, customers and investors about them?

(Ferrier and McKenzie 2002, p. 6)

Organisations asking these sorts of questions are trying to identify, assess and manage the intellectual capital available through their employees. According to Ferrier and McKenzie, Karl-Erik Sveily offers a framework to understand intellectual capital that has as the 'agent of business' the people who make up the organisation. The three groups of 'intangibles' Sveily identifies are:

• Employee competency, which he describes as the capacity of employees to create intangible and tangible assets in different situations. It is this 'competency' that is the source of the other two intangibles in the framework, the internal structure of the organisation and the external structure.
• Internal structure consists of the concepts, systems and organisational culture and spirit.
• External structure involves the relationship with the clients of the organisation.

To ensure maximum productivity, organisations need to manage the 'flows' in these groups by monitoring for growth, renewal, efficiency and stability. Looking at the organisational assets through this lens provides a focus on the front-line worker since every single person in the organisation matters, particularly where the work involves knowledge management or knowledge creation. Highly technical environments require current knowledge and updating of skills. Nurses and nurse educators are front-line workers in many of these environments and are actively involved in knowledge management and knowledge creation. Nurses have a key role in promoting and developing efficient systems and in building relationships with clients/patients. Nurse educators, whether in academic or practice environments, are essential in assisting other nurses and student nurses to develop high-level competencies and their theoretical underpinnings. These competencies enable nurses to function in a manner that promotes safe practice, and to have the skills and attitudes to work as part of a team to ensure the best care of the patient/client by building and promoting systems of support and good relationships with patients.

How do organisations such as health care and education, which are dependent on knowledge, achieve better productivity? They can do so by the following actions:

• Provide continuing development to all levels of workers, but particularly for those working in rapidly changing specialisations or areas where knowledge is developing rapidly.
• Invest in the development of staff to build a strong knowledge and skill resource base that will help the organisation meet new demands. Staff development can be achieved...
through mentoring, training and providing opportunities to use and extend skills, as well as incentives to develop and fill new and developing roles and transit within the organisation.

- Provide incentives for participation in sharing ideas and knowledge to improve the effectiveness of staff. Rigid hierarchies will be barriers to this occurring, as will strict professional boundaries.
- Use external networks and partnerships to add new competencies and/or knowledge.
- Promote evidence-based decision making and support research and its application.

3.5.3 Partnerships—the essence of constructive change

A range of partnerships offers the potential to improve care services and develop nursing. The partnerships need to be developed at all levels, from those people and organisations working on government policy, to those supporting particular community groups, to those that provide the links between education and practice.

Among the key partnerships for health organisations are those with education providers. Both systems depend on each other. Education and training need to be relevant to the services in which the new professional will work. Conversely health care depends on the quality of the education to accomplish its role effectively. Overarching the work of these two types of organisations and the systems in which they operate are the policies and funding systems of governments. If either policies or funding are considered in isolation, it will be difficult to achieve the types of operations that allow the relationship between education and health care to be productive. The result will be ad hoc decision making and contested responsibilities.

Education practice partnerships

As mentioned earlier in this chapter, research is leading to new thinking about the education of professionals. According to Gonzi the result is a shift of focus in "learning theory from the individual to the social setting" (2002, pp. 14–15). He suggests the way forward is a much stronger involvement of the practice community in education.

We need, too, a wider conception of learning which acknowledges that learning is developed through doing, through acting in the world. It is a process which involves the emotions and the formation of identity through adapting the world in which the person is situated— in the communities of practice that we live and act in.

The challenge is to shift the focus of professional and vocational education from training the individual mind, to the social setting in which the individual becomes part of the community of practice, from facts and rules stored in the brain until the need to use them, to enacting knowledge through activity, from a conception of humanity centred exclusively on the brain to a wider conception where humans are seen as embodied centres embedded in the world.

(Gonzi 2002, pp. 15–16).

The importance of the partnership approach is particularly evident at the time of induction of new health professionals. The Organisation for Economic Co-operation and Development (OECD) report suggests that the new professional has to bring together theoretical and practical knowledge developed during education and training when they begin to practise. The transition from student to worker is often a problem from the novice’s point of view. While the following material is discussing engineering rather than nursing, the comments show the importance of the link between education and the industries in which the practice professions are found.
Linking the two types of learning is one of the most daunting challenges in the education of professionals. Greater interaction between academe and industry in relation to knowledge production could usefully spill over into the investigation of best practices in the education and training of engineers, with useful lessons of mutual value. Whilst lessons from industry to the university are potentially important for the pre-service training of engineers, lessons from the university to industry will be of growing importance for the lifelong learning and continuing development required for practitioner engineers. (OECD 2000, p. 55)

Community partnerships
Coming out of difficult times there has been the growth in rural areas of what are termed ‘healthy communities’. Vibrance, resilience and sustainability mark these communities. There is a sense that the community believes the future is in their hands. These communities value and invest in education and training at all levels, including support for career transitions (Strengthening Community Unit 2000). Since health, aged and community care are essential components of all communities there is considerable potential for these types of rural communities to form alliances to promote educational pathways (and thus career pathways in nursing) and through this means sustain their hospital and aged care facilities.

3.5.4 Systems that promote individual advancement and progression
The opportunity to develop throughout the adult years can be maximised when the system of education and training encourages people to broaden their skills or increase their skill levels while acknowledging the knowledge and skills they have already gained. The capacity of the education and training system to assist those workers who have already gained competencies relevant to another occupation or professional preparation should be enhanced and access to further education and training encouraged. For the future, when competition for workers will increase, the facility to use and develop employees interested in progressing in a career in health care, whatever their initial starting point will be important for the flexibility of the various sectors involved in care and support work.

The current systems of education and training are building in the recognition of current competencies and cross-sector qualification linkages. The national training packages developed under the Australian Qualifications Framework map between competencies to facilitate movement between different levels and occupational streams. In addition, the Australian Vice Chancellors Committee (AVCC) has a policy to support cross-sector qualification linkages in order to develop closer links between VET and higher education (AVCC 2001). The guidelines promote more efficient pathways between qualifications within the same, similar or complementary specialisation or fields of study. Used well, this system has encouraged universities to give significant credit to enrolled nurses beginning undergraduate nursing programs.

Some of the current barriers to maximising this system have been the different preparation of enrolled nurses in the various States and the assorted attitudes of universities to the provision of credit. Despite these limitations, the Australian system has been remarkably flexible in providing opportunities to enter nursing from a range of different entry points, with credit where appropriate, whether through graduate programs, enrolled nursing, TER applications or adult entry provisions. Australia is in an excellent position under the established arrangements and policies to maximise the flow into and between different
levels of nursing. Nursing now needs to build its education and training to maximise on the principle of articulation between courses and training modules and also those of related professions.

3.5.5 Flexibility
The characteristics of flexibility and adaptability are identified as important in the evolving healthcare system (Department of Health 2000; Pew Health Professions Commission 1995 & 1998). More generally, research points to positive outcomes associated with the adoption of flexible workplace strategies. Flexible workplaces are associated with particular work practices and behaviours including flatter management structures, greater devolution of authority, work teams, fewer job classifications and higher levels of training of front-line workers (Selby Smith et al. 2000).

Nursing, as the largest professional group in health care, contributes significantly to the level of flexibility available to the system. The literature identifies two types of flexibility: numerical flexibility and functional flexibility (Selby Smith et al. 2000). Numerical flexibility relates to the ability to change the amount of labour available and functional flexibility relates to the quality of labour. While there is evidence that Australian hospitals have developed policies to promote numerical flexibility through casual nursing labour, the evidence also suggests that maximising functional flexibility has received insufficient attention.

The broad-based, comprehensive preparation of nurses support functional flexibility in organisations. It is a particular strength of Australian nursing. This is demonstrated by the responsiveness of nurses in the development of new skills and specialisations.

Nurses are in a responsive role in our system because they follow medical breakthroughs in terms of developing new roles and new programs of education. This can be traced from the 60s when ventilators enabled individuals to be kept alive and doctors became intensivists and needed skilled nurses to nurse patient on ventilators. Without nurses, medical specialists cannot practice. So given this framework, we know that tomorrow if medicine changes and a new role emerges for nursing then immediately nursing will require a new specialty or model of care. As surgeons have been able to turn patients over more quickly they have developed the role of Case Manager to ensure their patients have the same or a better level of care than previously when they remained in hospital until they had healed.

(NSW College of Nursing, response to Discussion Paper)

There are growing pressures to specialisation and sub-specialisation in nursing, which in response to the highly technical developments in medicine. Care should be taken to ensure that nursing does not lose the innate flexibility and adaptability that is its strength by pursuing increasing levels of sub-specialisation.

There are also lessons to be learnt from overseas experiences in relation to skill mix and work organisation. In the United States and Canada, the escalating costs of providing health care, combined with shortages of nurses, have driven changes in work structure in hospitals. Many healthcare institutions have been downsizing, increasing the proportion of casual workers, reducing nurse management positions and introducing larger numbers of unskilled or semi-skilled workers. These changes have made particular demands on the flexibility and adaptability of nurses, often with unintended consequences.

Some of the consequences of the use of a multi-skill level workforce could be a decrease in the ability of organisations to restructure work in response to a shift in demand. Some
patterns of work structure and practice produce a reduction in the attractiveness of nursing as a career, impact negatively on patient outcomes and may not be cost effective (Aiken & Havens 2000; Aiken, Clarke, Sloan, Sochalski, Buse, Clarke, Giovannetti, Hunt, Rafferty, & Shamian, 2001; Fagin 2001). Aitken and team (2001) say that Vincent (1996) argues that to achieve restructuring, employees must be able to function autonomously, be self-directed, knowledgeable, flexible, empowered and require little supervision. Vincent puts the position that the use of unregulated workers is likely to increase traditional supervision and has the potential to create a reductionist and mechanistic view of nursing. There is some evidence that this is what has occurred in aged care in Australia due to similar pressures.

The above findings suggest that to achieve the right balance of skill mix and work organisation to enable nurses to work at the level of their education and training will require some careful and sophisticated research. The answer will be context-dependent since the work of a nurse in community care is very different from that of a nurse in intensive care in a hospital. One of the factors that will need to be considered in the research is the impact of different arrangements on the capacity of the workforce to respond to future shifts in demand for services. Another issue to be addressed in work restructure is the need to ensure nurses are not removed from the work of direct patient care, since this is likely to make nursing less attractive as a career.

3.5.6 Inclusiveness of the profession
Nursing should reflect the ethnic mix of the Australian community. As a service in a multicultural nation, reflecting the mix of culture will enable nursing to be more responsive and sensitive to the different expectations, beliefs, values and understandings of people. If being a nurse entails developing an interactive/interpersonal therapeutic relationship that permits her/him to gain knowledge of the whole person and the ways in which each person defines their experience of illness (Maries 1988, S28 p. 26), then cultural understanding, sensitivity and safety are essential. These qualities form the essence of such a relationship and are best gained within a profession that is representative of the different cultural groups.

Indigenous Australians also need to be well represented in the nursing profession. Sufficient Indigenous nurses provide an opportunity for Aboriginal communities, particularly remote communities, to control their healthcare services. Indigenous nurses assist non-Indigenous nurses to better understand the different issues that affect health and so create more inclusive and effective health services for Aboriginal and Torres Strait Islander people.

Further, men are not well represented in the nursing profession. Attracting more men into the profession is essential as nursing needs to revise its profile so that it becomes, like most other new professions, gender-neutral. In a competitive employment environment, nursing will need to capture all those who have an interest in this work. Nurses need to position their profession as one that promotes an inclusive image.

3.5.7 Access
While positioning itself as a competitive profession, nursing has already the advantage of pathways that enable those who have been disadvantaged in their schooling to make their way into the profession. Promoting these pathways and supporting those who wish to develop their careers will be essential to the development of the nursing profession. Strengthening the linkages between industry, VET and higher education will be part of
promoting an inclusive profession that offers a range of career options and possibilities for development.

Governments will need to play an important role in supporting education and training for nurses and trained care assistants and ensuring access for those from disadvantaged backgrounds. The community depends on the competence and caring of nurses and trained care assistants, most of whom will work in areas that will not be able to offer the sorts of remuneration other professions (such as law and medicine) can. Promoting the value of community service is a matter of being seen to value the work of those who provide this service.

3.5.8 Creative and wise use of technology

A range of evolving technologies will challenge both the way healthcare services are delivered and the education and training needed for health professionals. Information and communication technology in particular offers the potential to overcome the limitations imposed by vast distances and sparsely populated lands that challenge the delivery of health and education services in rural and remote Australia.

The OECD (2000) suggests that the impact of information and communication technologies on potential developments in health and education could be in two significant and contradictory directions. The technologies can increase the use of centralised, linear models of knowledge production, mediation and use, and at the same time offer the potential to generate new forms of de-centralised networks that will produce and disseminate knowledge in radically new ways.

While the former use encourages centralised policy development and dissemination of best practice, this could lead to a simplistic belief that all that is needed to achieve good practice is to define and share information about it. Such centralist approaches will have little ultimate influence without recognition of the many factors that cause dissemination and implementation to fail.

In contrast, the possibilities of new forms of networking between individuals and organisations could cause radical changes in organisation structure. The OECD report (2000, p. 57) lists questions asked by Coombs and team (1996), three of which have particular relevance to this discussion:

- Are networks a temporary phenomenon created by the novelty of ICT [information and communication technologies] or does it open radically new ways of conceptualising knowledge production and dissemination?
- Will collaborative networking lead to a revision of understanding of processes of competition and wealth production?
- What changes might this make to our understanding of organisations (firms, hospitals, schools) and the way they are managed?

Whatever the direction the different technologies take education and health care, they will have a radical impact on both, and consequently on decisions about nursing education, research and practice.
3.6 Conclusion

At the conference ‘Designing the future clinical healthcare workforce’, 11–12 June 2002 in Brisbane, Mullan listed the issues for health care in the 20th century as access to services, by which he meant the availability of primary care, drugs and basic hospital services. In addition to access he noted other issues were the distribution of services, their quality and cost; as well as getting the number of staff right. In contrast, he predicts the 21st century will be one of rolling innovation and patient empowerment, stimulated to some degree in response to information and communication technology innovation. If he is correct, planning for the future must include evolving a system of care and education that has the capacity to judge judiciously and respond effectively. Evolving a system of care is dependent on the values that underpin these two systems, education and health, because these values influence the outcomes expected of the systems— that is, what will be considered as the achievements of the system. The responsiveness of the system is very much reliant on the attitudes and capacity of the people delivering these services.
4 Emerging models of care

The Review Panel was asked to consider the types of skills and knowledge required to meet the changing needs of the nursing workforce and the changing context of nursing and health requirements. This chapter examines developments and trends in models of care, their impact on patterns of nursing and their implications for nursing and educational provision.

In considering these matters, we have adopted a broad approach, focusing on principles and directions to guide nursing education for the future (rather than specifying skills and knowledge sets), and used case studies to illustrate developments and responses. When examining the impact of developments on patterns of nursing and nurse education, we have used the term 'competencies' rather than 'skills and knowledge'. It is important to recognise that in this context 'competencies' refer not just to skills but also to the related knowledge and attitudes. We use this rather than 'skills and knowledge' because it is comprehensive in nature, as competencies are built from combinations and packages of skills, related knowledge and attitudes. The use of the term 'competencies' highlights the importance of and interrelationships between the concepts of skills, knowledge and attitudes. It is also consistent with other areas of educational, training and practice development.

4.1 Developments and trends

In considering emerging models of care, we were struck by the lack of Australian research on changed patterns of nursing. At the same time, submissions and consultations highlighted many instances of innovative education and training approaches in parts of Australia, in areas of nursing and between nursing and other professional disciplines, to meet the changing needs of the health, community and aged care sectors.

New models of care have been developed in response to:

- the move away from institutionalised care in hospitals, aged care, mental health, and for people with disabilities, to community-based approaches
- greater focus on providing seamless delivery of care particularly for the frail aged, chronically ill and those with other complex care needs
- improvements in efficiency, safety and quality of care.

Types of care offered, the ways they are provided and the competencies required by health professionals will continue to alter. For nursing, the following trends are evident:

- increasing specialisation and sub-specialisation in some areas of nursing
- a move to highly skilled generalists in others
- the combining of some specialisations with others
- multi-professional approaches.

These trends are not unique to nursing. They are occurring among other groups of health professionals—for example, the medical workforce is undergoing similar changes (Department of Health and Aged Care 2001). Examples of these trends are provided in the following sections.
4.2 Changing role of hospitals—increasing specialisation

The nature and role of hospitals have changed considerably over the last decade. Acute care hospitals have become complex, specialised institutions for patients who require the high level of care and technology provided only within hospitals (Hillman 1999). Average hospital stays have shortened. There has been an increasing trend towards day surgery and procedures, with treatments that previously required admission now being provided in outpatient clinics and day care facilities or by community-based health services. More intensive care and high dependency beds are required, while the total number of acute care beds is decreasing as the more ambulant and less sick are treated elsewhere. New models replace some traditional hospital treatments (for example, day surgery and birthing centres).

The government and non-government sectors provide acute hospital care. The government sector is the dominant provider (in terms of hospital numbers, available beds, admissions and separations). However, the role of the non-government sector is changing. More types of services are provided (elective surgery, accident and emergency services, on-site diagnostic services, medical centres and consulting rooms). Non-government hospitals are being collocated with government hospitals to share human and technological resources and access to emergency government hospital services. Partnership arrangements between the two sectors are being developed whereby non-government hospitals are contracted to provide services to the government sector. Employment opportunities for nurses in the non-government hospital sector have increased. Hospitals continue to be the major place where nurses work in Australia. The majority of nurses worked in hospitals in 1997 and about 62 per cent were employed in acute care/psychiatric hospitals (AIHW 2001d).

Acute care nursing has become more specialised, more technologically driven, and more intense. A number of respondents reported on the increasing specialisation in care in such areas as critical care, intensive care, coronary care, surgery and emergency medicine, and the ways in which nursing practice has been revolutionised.

The changing nature and role of hospitals will have wide-ranging effects on the education and training of Australia’s health workers. Nurses will need to be able to care for an increasingly ill population of in-hospital patients. This work will demand highly developed social skills, the use and management of a range of technologies and the knowledge and understandings that inform the best systems of care. Clinical experience and continuing education and training are becoming increasingly important to maintain competencies and knowledge, and to keep up to date on new developments.

4.3 Community health focus

Nurses have an important role in community care and in population health promotion and screening. In these settings their roles are diverse and developing. The following descriptions from Jones and Cheek (2001), who interviewed nurses in a range of work settings, testify to the complex roles that nurses undertake in the community.

Melanie is an enrolled nurse (RN Division 2) who works in community palliative care in Victoria. In one day Melanie will see five or six clients in their homes, all of whom are terminally ill and have usually requested to die at home rather than in hospital. She will assist the client in hygiene and will provide support to family members. Melanie is left to organise her own day, which is not as task oriented, and enjoys the independence that work in this practice area brings, particularly because it enables her to spend time communicating with clients and their families. The nature of Melanie's work...
work means that there is no typical day and she is often unsure of the environment she will encounter behind each door. Melanie is regularly involved in conflict resolution either between family members or on occasions where clients or their relatives relinquish their frustration and aggression on her.

David is a registered nurse employed within a community based alcohol and drug service in rural Queensland. His client base is around 30,000 people from the surrounding shires, comprised of a number of small communities. In his role, David is responsible for counselling of persons with drug or alcohol addictions, arranging detoxification referral and set-up, and support and education of hospital staff (medical and nursing) involved in the detoxification process, and in constant liaison with local GPs. The aim of David's involvement, he says, is based on ‘harmonisation’—bringing the client back in control of their life. His is a holistic approach which looks at the client's lifestyle, relationships, past, future, and their physical and emotional functioning. His role is to set up the client's detoxification program in a local area, or to give the person details of facilities in other towns close by.

Jill is a registered nurse who works closely with two other Level 2 RNs in a Child health service. The service is located in a metropolitan shopping area so as to be more accessible to clients. The majority of infants Jill is involved with are 0–3 years, although the clinic caters for children up to 12 years of age. Generally, the clinic is an information service for parents. Most commonly, Jill is involved in ‘wellness’ assessments of infants at key developmental stages. These assessments involve examining the child's growth, and their physical, mental and behavioural development. These assessments are aimed at gaining early intervention for any developmental abnormalities suspected. Jill will refer the child and the parent to a medical officer or a GP if she feels there may be an issue beyond her scope as a nurse practitioner. She may also become involved with other social family issues, such as those that arise with very young mothers, and domestic violence and post-natal depression. With these social issues, Jill will aim to gain an insight into the general background of the family, and refer the client to other suitable services.

Laura works as an enrolled nurse in a school in Western Australia. The school is an education support school that takes students who have both physical and mental handicaps. Laura describes the type of nursing she does as community nursing, which involves prevention through empowering and educating people. A large portion of Laura's work will involve health promotion and student advocacy. She conducts information sessions for students on topics such as school bullying, building self-esteem and a feel safe program. Laura will also attend to playground accidents and school outings. Laura's employer is a local hospital, rather than the school.

4.3.1 Primary care

The trend from institutional care to community care has been increasing. A greater share of pre- and post-operative care, management of chronic illnesses, mental health and aged care is now provided in the community. Specialities such as psychiatry, geniatrics, rehabilitation and palliative care are increasingly community-based.

Responsibility for primary and community care services is shared across Commonwealth, State and Territory and local governments. This split in responsibilities has created difficulties for the delivery of services. Many Review submissions commented on the problems that such division in responsibilities, service fragmentation and inflexibility in funding present for the provision of care to patients and their carers. However, some projects and strategies have developed to help reduce this fragmentation.
4.3.2 Current initiatives
A number of efforts are underway by Australian governments to improve the capacity to provide continuing care and support people with chronic conditions or general frailty. One example of such an initiative is enhanced primary care packages. These help people with chronic illnesses and complex care needs (many of whom are older Australians), as well as their carers and the health professionals who look after them. Another is coordinated care trials to improve the integration of various health services and ensure clients' needs are placed at the centre of service planning, funding and delivery.

Also, Australian governments have for the first time agreed on priority areas to improve services that build on past efforts (Department of Health and Ageing 2002c). Agreement on priority areas centre on improving:

- continuity of care for consumers through developing and maintaining greater integration across the primary health and community care sector
- quality, appropriateness and cost effectiveness of care by strengthening the interface between hospital care and community-based care.

The latter includes a focus on improving relationships between hospitals, emergency departments, outpatient departments and general practice; pre-and post-hospital care provision; and strengthening the role of primary care providers in population health.

4.3.3 Primary care or primary medical care?
A common concern expressed in submissions and consultations was the focus of many government initiatives on medical care in which general practice is seen as the centre of primary care and enhanced primary care is largely expressed as enhanced medical care. While much of the attention has been on initiatives that have a medical focus, nurses are essential to the delivery of services in the community. Their role in these services is expanding and the trend will place new demands on nurses' professional roles, nursing education, training and professional development, and nursing work organisation and planning. Policy makers at all levels also need to consider the ways in which nursing is integrated into new models of primary care and community care to ensure effectiveness, efficiency and quality in service delivery, health outcomes and costs.

4.3.4 Population health initiatives
The scope of population health activities is expanding from traditional activities, such as population screening, immunisation, communicable disease control and surveillance, to areas such as surveillance of disease risk factors, management of healthy growth and development, mental health promotion and consumer product safety. Nurses' work is also expanding in public health.

4.4 Integrated hospital and community care—combining specialisations
Integration of services across the continuum of acute and primary care has become a major focus in healthcare delivery. Greater emphasis is being placed on the interface between hospital and community care as hospital stays are reduced and more care is provided at home. Nurses provide a vital role in this interface to facilitate a smooth transition for patients and their carers. Integrated care requires new combinations of nursing...
specialisations and multi-professional approaches to care planning and delivery. One example is Hospital in the Home.

Hospital in the Home
Hospital in the Home is an Australian example where the nurse is the vital link in the integration of hospital and community care. Services that were traditionally hospital-based are now provided to patients in the convenience and comfort of their home environment. Hospital nurses, rather than community-based nurses, deliver care in the client's home. Services include administration of intravenous therapy, chemotherapy, complex wound care and anti-coagulation and neonatal services (Aitken et al. 2001). Nurses providing services require both their hospital-based clinical expertise (for example, in oncology or neonatal care) and expertise in community nursing. They also need the ability to work independently, knowledge of general practitioner and other primary care services, and skills in adopting multi-professional approaches to health care in a community setting. Knowledge of quality improvement processes to support policies specific to their own services and standards and criteria to guide and measure practice are also necessary (Aitken et al. 2001).

4.5 Coordinated care—multi-professional care planning and service coordination

Coordinated care seeks to provide the right care at the right time to patients and clients. For many people with chronic and complex care needs, care is provided by a number of separate service providers and funded by different levels of government. Often the result is that people receive the care they can get rather than the care they need. Coordinated care aims to overcome traditional professional, organisational and funding boundaries by focusing on patients' care needs. One major Australian initiative is the Coordinated Care Trials.

Coordinated Care Trials
Coordinated Care Trials are examining whether multi-disciplinary care planning and service coordination lead to improved health and wellbeing for people with chronic health conditions or complex care needs. The trials test different approaches to achieving this. Funds pooling between the Commonwealth and State and Territory governments is being tested to give funding flexibility to support a coordinated approach to service delivery. Funds have been pooled for health and community services for each trial's participants. Each client has a care coordinator who works with the client to develop a care plan. Care coordinators vary across and within trials and may include general practitioners, nurses, home care coordinators, and allied health professionals. The care coordinator draws on money from the funding pool to buy the full range of services set out in the plan. Trials are undertaken as joint collaborations across a range of health professional services, health and community services and other organisations including nursing.
4.6 Aged care

Australia's ageing population, healthcare delivery, health promotion and community support arrangements influence the educational needs of those working in aged care. Aged care crosses all areas of the health sector and intersects with other sectors. Australia's older population uses services provided for the general population (such as hospitals and community health services) and services provided specifically for older, frail people. The core elements of the Australian aged care system are:

- aged care assessment teams that determine eligibility for community aged care packages and for admission to residential aged care facilities
- home and community-based services provided through the Home and Community Care program
- community aged care packages
- residential aged care facilities.

4.6.1 Variety of settings

Nursing care for older Australians is provided in all settings—residential, community, acute and non-acute. Aged care is another large and growing area of employment for nurses (registered and enrolled) and for trained care assistants (Johnson & Preston 2001). Aged care has long been considered a low status area of nursing, with nurses preferring to work in acute care settings but often finding work in aged care because it suits family commitments or they are unable to gain suitable employment elsewhere (Pearson et al. 2001). Key concerns in aged care nursing are the retention and recruitment of a sufficient number of qualified nurses in the workplace and achieving an appropriate skill mix and education and training for nurses and care assistants to meet changing needs and models of care delivery for the elderly population.

4.6.2 Models of care in the home

Models of care that help people remain in their own homes as an alternative to being placed in low-level residential (hostel) aged care have been introduced as part of the shift from institutional aged care. Community Aged Care Packages provide a range of home-based care services with care coordinated by the care package provider. The Home and Community Care Program provides the bulk of home and community-based services, many of them by not-for-profit agencies. The program includes nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, paramedical services, home and centre-based respite care, and advice and assistance of various kinds.

An indication of the expansion in and volume of services provided to older Australians at home is provided by the Australian Institute of Health and Welfare (AIHW). In 1999, 13,725 care packages were provided representing 8 places per 1000 persons aged 70 years and over, compared with 1277 packages in 1994 (when packages were first introduced) and 6124 in 1997 (AIHW 2000a). In 1997-98, the Home and Community Care agencies provided 441 hours of home help per month per 1000 people aged 70 and over and 506 hours of centre-based respite care and 697 delivered meals per 1000 persons aged 70 and over. Some 127 hours of home nursing were provided per month per 1000 residents aged 70 and over (AIHW 2000a).
4.6.3 Residential aged care
Australia's residential aged care sector covers nursing homes and hostels. Its case mix is changing, with the sector now catering for an increasing proportion of high dependence residents. The AIHW reports that, between 30 June 1998 and 30 June 2001, the proportion of residents classified as high care rose from 58 per cent to 63 per cent while those classified as low care fell from 42 per cent to 37 per cent (AIHW 2002a). Government hospitals also provide nursing-home type care to some patients. In 1997–98, there were some 10 548 separations of nursing-home type patients with an average length of stay of 109 days (AIHW 2000a). These trends are expected to continue.

4.6.4 Education to work in aged care
Pearson, Nay, Koch, Ward, Andrews and Tucker in their recent study of recruitment and retention of nurses in residential aged care (2002), report on the lack of acknowledgment within the aged care sector and the general community of the complexity of competencies needed for the effective and appropriate nursing of older people. Factors cited as contributing to this situation include:

- the low participation rates of aged care nurses in specialist award courses in gerontological nursing
- the generally accepted view that while acute care nurses, such as those in intensive or emergency care require specialist, advanced knowledge or competencies, such a requirement is not expected for nursing older people.

The study considered that these factors also serve to devalue the role of aged care nursing and render it a low status pursuit.

Studies indicate that, within the aged care sector, there is significant variation in the proportion of different levels of nurses and care staff and the competencies they possess. An inappropriate skill mix affects patient care, work satisfaction, effective recruitment and retention, and effective and efficient resource use. Pearson and team (2001) recommended examination of an appropriate nursing skill mix in the aged care sector. We support the thrust of this recommendation while noting that the examination should cover the appropriate level of competency for different groups of workers in care work as well as the appropriate skill mix.

Collaboration between education and aged care sectors
Collaborative efforts between educational institutions and aged care facilities are being forged to improve responsiveness. Examples include:

- The Warabrook Centre for Aged Care operates in conjunction with the University of Newcastle. The design of the home incorporates the needs of the university, providing a training room and lunch area for visiting students including nursing students.
- The La Trobe University Gerontic Nursing Clinical School, located at Bundoora Extended Care Centre and linked to the Australian Centre for Evidence Based Residential Aged Care, provides practice-focused education and training for enrolled nurses and undergraduate and postgraduate nursing students.
- Blue Care Queensland is working with Queensland University of Technology to develop and deliver postgraduate courses in aged care nursing. They are also party to a project to establish benchmarks of aged care clinical care and quality of life indicators.

Collaborative efforts and multi-professional approaches need to be strengthened and promoted as part of ensuring that educational provision responds to the changing needs of the aged care sector and provides a sustainable aged care nursing workforce for the future.
4.7 Mental health

Mental disorders are a major and growing cause of disease burden in all countries (AIHW 2000a). Mental health has been identified as a National Health Priority Area and mental health planning has been recognised by World Health Organization as a global concern. Over the last decade, the delivery of services to mental health patients has shifted from a predominantly institutional approach to a mix of institutional and community-based services such as ambulatory and 24-hour residential care. De-institutionalisation occurred along with an emphasis on mainstreaming mental health services. Psychiatric wards moved from large, stand-alone psychiatric hospitals to become part of acute care hospitals. Acute psychiatric units are treating a more complex client group and community mental health teams provide crisis intervention and other outreach services including case management, psychiatric liaison and other specialist services.

4.7.1 Mental health nursing

Mental health nurses are core practitioners in both in-patient and community services. They deliver services in metropolitan, regional, rural and isolated settings. Mental health nurses are the largest component of the mental health workforce in Australia, accounting for 75 per cent of all mental health professionals (Carter 1999 cited in Clinton et al. 2001).

4.7.2 Developing multi-professional practice standards

Multi-professional team approaches are an important feature of mental health practice. Practice standards to support the move to multi-professional team approaches in mental health practice are under development as part of the National Mental Health Strategy. The National Practice Standards for the Mental Health Workforce are being developed in consultation with the five mental health professional disciplines of social work, occupational therapy, nursing, psychology and psychiatry (National Mental Health Education and Training Advisory Group 2001). These standards will provide a benchmark for mental health practitioners to work towards, with the aim of achieving the standards within two years of entering the mental health workforce. They also offer a strategic national framework for the education and training of the future mental health workforce which can be used by educators in the development of undergraduate and postgraduate curricula and continuing education programs.

4.7.3 Developing and maintaining an effective mental health workforce

Maintaining an effective mental health nursing workforce is critical. To achieve this all nurses require a strong foundation in mental health as part of initial education and training. In addition nurses with a specialisation in mental health are needed. Mental health could be an area for the development of enrolled nurse specialisation. Those with a specialisation are in short supply and numbers need to be increased.

Several groups are developing innovative approaches to undergraduate education on mental health issues aimed at attracting student nurses to ultimately specialise in mental health nursing. One example is the Grampian Psychiatric Services/University of Ballarat where service providers and educators are working collaboratively in undergraduate education and training in mental health nursing.
There are a number of factors that may influence a third year student's decision to specialise in psychiatric nursing. One of the main factors is a student's university experience. Few students consider psychiatric nursing before entering university. The university experience is the one area where the psychiatric nursing profession has the potential to make a difference, and students have identified the first clinical placement as the most critical factor in decisions made about mental health nursing. It can reinforce negative ideas or can create a major positive shift in the student's thoughts on psychiatric nursing.

Recognition of these issues resulted in staff from the University of Ballarat and Grampians Psychiatric Services (GPS) getting together and coming up with a better way to deliver the psychiatric nursing component of the comprehensive nursing course. The basic agreement was that there would be an increased amount of theory, a coordinated approach to theory relating to practice, and more involvement by GPS staff across the program and support for students and staff. The model revolves around the development of four units of psychiatric nursing. These four new units were designed to provide as much theory as possible, to ensure that the theory related to practice and to emphasise the specialty of psychiatric nursing. Two units were allocated to each of second and third year.

It was decided to utilise as many GPS staff as possible in the delivery of lectures and tutorials. This gives staff working in the field the opportunity to share their experience, as well as offering students the opportunity to meet real psychiatric nurses, thereby breaking down some of the stereotypical images. Clinical placements take place in both second and third year. There is also opportunity for an extra psychiatric nursing placement in third year as an elective. Students are placed across all areas of the service.

A full evaluation report on this initiative will be available later in 2002. However, the University of Ballarat has advised that the outcomes achieved so far with this new model have exceeded original expectations. A preliminary student evaluation survey indicated that students viewed their clinical experience at Grampians Psychiatric Services as one of quality. Approximately 80 per cent of students surveyed reported that they were able to achieve their learning objectives, apply theory to clinical practice and receive accurate assessments, and that they would consider a career in mental health nursing.

4.8 Rural and remote

People living in rural and remote areas face particular health challenges and concerns that relate to their living conditions, social isolation and distance from services. The rural health workforce comprises nurses, medical practitioners, allied health, pharmacy, hospitality, administrative staff and others. Despite the need for all these groups, attention often centres on the perceived rural doctor shortage with numerous efforts undertaken to put in place a stable, sufficient and appropriately skilled medical workforce, particularly general practitioners (Best 2000). Comments to us often focused on the different approaches rural communities took to attract different health professionals.

The face of rural health services in Australia has changed considerably. There has been significant restructuring of services from primarily acute medical services to primary care or aged care services, amalgamation or collocation of services, closure or downgrading of services, expansion of midwifery and surgical services, and development of multi-purpose services and centres. Australian rural and remote practice is characterised by a close relationship between acute and community services.
4.8.1 Nursing in rural and remote settings

Rural and remote areas are particularly dependent on nurses for their healthcare services. Except for nurses, there is a much lower provision of health professionals in rural and remote areas. In 1999, approximately 16.1 per cent of the general medical workforce was located in rural and remote areas, despite 28.4 per cent of the population living in those areas. At the same time 30.4 per cent of the registered and enrolled nurse workforce were working in rural and remote areas (AIHW 2002c). For many isolated rural communities, registered nurses provide the first point of contact for a range of primary care functions that, in metropolitan areas, would often be provided by general practitioners and other health professionals.

Changes in rural health services have led to significant changes in the role and function of rural nurses. There has been a shift towards community-based services, population health and multi-disciplinary decision making in partnership with communities. Rural nursing practice is context-specific and highly generalist in nature. Activities undertaken by the rural community health nurse range from ensuring access to breast screening programs, to interventions dealing with rising organochlorins in the food chain, to campaigns to reduce road trauma among rural youth (Francis et al. 2001).

Common challenges identified in the literature include professional isolation, scarce resources, the expectation that practitioner skills will be more generalist than specialist in nature, limited scope to specialise, legal implications of practising an expanded role, and identifying professional boundaries of practice (Francis et al. 2001). As noted in Chapter 2, some States and Territories have explored the potential for nurses taking expanded roles as nurse practitioners to meet needs of rural and remote communities. Approaches have varied and progress has been slow, partly due to lack of support from parts of the medical profession, concerned about the impact of substitution on their practice, and a focus by some groups on payment arrangements under an independent fee-for-service practice model (Duckett 2000).

4.8.2 Education and training challenges

The demands of rural and remote practice pose challenges for the education, training and professional development and wellbeing of nurses and other health professionals. Educational provision must be responsive to the competencies required to practise effectively and efficiently in rural and remote settings and environments, as well as the problems nurses and other health professionals face in accessing education services and professional isolation. Innovative approaches to addressing these challenges are unfolding. One example is the Rural Health Education Foundation, a not-for-profit organisation delivering live interactive television education to rural and remote health professionals through a network of over 450 satellite receiving sites. Some of these programs are specifically for nurses. Information about the Foundation is available at <rhef.com.au/index.htm >.

4.9 Midwifery

In all States and Territories, to work as a midwife, a person must hold current registration as a midwife or be authorised to work as a midwife. While this is the common requirement, there are inconsistencies across States and Territories in the education of Australian midwifery and the standard of preparation (Leap and Barclay 2001).
Our duty of care

Shah and Burke (2001) report that the employment of registered midwives increased gradually over the period 1987–1999, with the last two years seeing a very substantial growth, reaching 10 000 by 2001. The number of registered midwives employed per 1000 births increased from 26 to 30 between 1987 and 1999. In 2000, it jumped to 42. Between 1987 and 2001 there was a large increase in the proportion of midwives working part-time with a corresponding drop in the proportion working full-time. According to the AIHW, in 1997 almost 29 per cent of registered nurses with a post-initial qualification had that qualification in midwifery (Shah and Burke 2001). Midwifery is the most feminised of all nursing occupations with on average only 2 per cent of men. Shah and Burke (2001) report that, in contrast to the growth in registered midwives, there has been a 2.2 per cent decline in the number of births over the period 1987 to 2000.

The role of the midwife has been undergoing a process of reassessment in recent times in many countries including Australia. This is in response to several factors including:

- changes in birth rates
- falling demand for obstetric services
- the capacity of health systems to use midwives effectively and efficiently and provide career paths for people with a midwife-only registration
- demand for services that offer continuity of care and are woman-centred.

Nurses have adopted expanded roles, coordinating and leading obstetric care work within multi-disciplinary teams (Aitken et al. 2001). New models of maternity care have developed in Australia and overseas to better cater for childbearing women in a more woman-centred way and to offer continuity of care (for example, birthing centres).

Direct entry midwifery courses began in 2002 in two States. This has been a fairly controversial development. While it may well promote midwifery to those who do not to 'nurse' and so expand the pool of available applicants, the ease with which they will find employment is an issue that will need to be tested by market forces. There are concerns that many settings will not be able to employ midwives without nursing qualifications. For example, remote Australia and Indigenous communities, where the highest birth rates occur, are unlikely to be able to sustain multiple health practitioners. In remote settings it is likely that any midwife would also need nursing skills and knowledge. While there may well be a place in changing models of care for midwives without nursing qualifications, there will always be a need for programs for registered nurses to gain an additional qualification in midwifery.

There are differing views about education in midwifery, as the following quote from Review submissions highlights. Some advocate midwifery as a direct entry course. Others support retention of postgraduate midwifery and some are happy that both options are available. The following response to the Discussion Paper summarises some of the issues.

The Bachelor of Midwifery program, which has been fully supported by The Australian College of Midwives (ACMI), has not gained unanimous support from each State and Territory. Whilst this School is supportive of the Bachelor program it would like to ensure that postgraduate midwifery is retained as a significant option. Current midwifery practice settings in Western Australia, many of which are in rural areas, make the concept of the non-nurse midwife difficult to accept. Most midwives in the rural setting, as well as many in the smaller metropolitan hospitals, are required to work as a nurse as well as a midwife. Future developments in practice may enable the introduction of more innovative midwifery models of care; however, it is not expected to happen in the short term. Workforce options would therefore be severely limited for midwives without a nursing qualification. The School will be interested to consider the
evaluation outcomes for those Bachelor courses that are about to commence in at least
two other States.
(School of Nursing and Midwifery, Curtin University of Technology, response to
Discussion Paper)
The Australian Health Workforce Advisory Committee (AHWAC) has a project that is
attempting to define a balanced supply of midwives to meet Australia's current and
emerging needs. It involves resolution of a complex set of matters that reflect the dynamic
nature of health care needs and importance of health care service and educational provision
responsiveness. It had not reported at the time of writing this report.

4.10 Indigenous communities

Indigenous Australians continue to experience much poorer health than the general
population (AIHW 2000a). Improving the health status of Indigenous Australians by
ensuring access to effective, high-quality care at the community level is a central concern.
Indigenous Australians represent a significant proportion of people living in remote areas.

4.10.1 Community empowerment, participation
and partnerships

Strategic approaches to improving the health of Indigenous Australians are based on the
principles of community empowerment, participation and partnerships. They include:
• long-term partnerships between Indigenous communities and organisations and
governments
• local health services providing integrated clinical and population health programs
delivered in ways that actively engage individuals and communities in managing
their health
• complementary action by mainstream and Indigenous specific services working
together with local communities to increase access to services and address specific
health problems and needs.

Some successes are already being documented in this regard. The Aboriginal Medical
Services Alliance, Northern Territory (AMSANT) in its submission states that 'Katherine
West Health Board challenged the misinformation about community controlled health
services by delivering better conditions, improved staff management and increased
effectiveness of the health service'.

4.10.2 Developing an Indigenous health workforce

Building an Indigenous and non-Indigenous health workforce is recognised as integral to
improving the health status of Indigenous Australians. Work is under way to put in place a
consolidated and integrated workforce development framework that builds workforce
capacity, training, recruitment, support and retention of Indigenous and non-Indigenous
professionals in Indigenous health. The Aboriginal and Torres Strait Islander Health
Workforce National Strategic Framework was developed by a drafting committee of the
Commonwealth, State and Territory Government Standing Committee on Aboriginal and
Torres Strait Islander Health (OATSIH 2002). The document was endorsed by the
Australian Health Ministers' Advisory Committee on 30 May 2002. The Workforce
Strategic Framework presents a five to ten year reform agenda to build a competent health
workforce to address the health needs of Aboriginal and Torres Strait Islander Australians.
Indigenous Australians are under-represented in all fields of health study except Indigenous health and public health training. In the period 1995–2000 the number of Aboriginal and Torres Strait Islander students commencing undergraduate health courses remained almost the same (312 in 1995 to 308 in 2000). In 2000 most of these students commenced undergraduate courses in nursing (82 students), general health support (81 students), and other health support (72 students), with 19 students commencing medicine (AIHW 2002c p. 275).

Some of the challenges of community empowerment for the education and practice of non-Indigenous nurses and other health professions are identified in the AMSANT submission to the Review:

AMSANT advocates for communities and individuals to take responsibility for our own health, and seeks a partnership between community leaders and health professionals to combine the skills and expertise of each to deliver appropriate health care. Some sections of the nursing workforce have been reluctant to acknowledge the greater authority of the Aboriginal leadership to address Aboriginal health needs and the rights of Aboriginal people to manage their own health care. AMSANT have encountered this resistance from nurses professional and representative bodies, as well as individual nurses in remote communities ...

The biomedical model teaches diagnosis and treatment in isolation from the wider social, economic, political and behavioural considerations. It privileges the health professional as the expert about the patient's health, and western medicine as having greater legitimacy than alternative health systems. The community-controlled model delivers a critique of western medicine and the relations of power and authority between the patient and health care provider. In our services, the role of non-Aboriginal professional staff is consultative rather than directive. The community-controlled model also critiques colonialist values and processes in health institutions and in wider society, challenging entrenched assumptions about biomedical superiority and cultural arrogance.

AMSANT believes that, in order for Aboriginal health to improve, the sector needs a workforce that can:
1. Communicate information and negotiate with individuals and their families about a patient's care
2. Support Aboriginal leadership on changing health institutions to become more responsive to patient and community needs
3. Work in partnerships across professional and representative groups for action to address the socio-economic determinants of health.

These issues need to be taken up in the training and professional development of the nursing workforce and in the policies of other employing bodies and professional associations. At the last CRANA conference, AMSANT challenged CRANA to support the Aboriginal model of health care. CRANA have responded positively, with a request to discuss opportunities for better collaboration around nursing issues in remote communities.

(Submission No. 137)

4.11 Harnessing information technology—e-health

Information technology is revolutionising the ways in which health services are delivered and organised, access to information and research, the nature of health records and modes of professional communication, education, training and development. Aitken and
colleagues (2001) reviewed the literature on telemedicine/telehealth in the provision of health care and nursing services. Increasingly, information technology will be used in healthcare delivery and education and modes of use and their impact will continue to evolve. Educational provision must be responsive to this rapidly changing environment. To deal with this environment, a range of responses will be needed including legislative, regulatory and other measures to protect and respect individuals' rights. Nurses will need to understand a wider range of legislation than previously. In their education, greater emphasis on ethical considerations and professional boundaries will be necessary.

4.12 Future directions for nursing education and practice

Developments and trends in models of care highlight the dynamic nature of health, community and aged care and the importance of building capacity within nursing and educational provision to respond effectively and promptly to emerging developments and changing needs. This poses several challenges for nursing and nursing education. Educational responsiveness to health, aged care and community care needs is vital to building a sustainable nursing workforce for the future. At the same time, nursing education needs to provide the foundation for ongoing education and a high level of problem solving and thinking skills. Defining one particular model of education and training in terms of time or content would limit the ability of educators to respond to the changes in the service sectors or the demands of the knowledge economy with its rapid changes in technology and scientific development. However, a number of factors that will assist in development of both responsiveness and quality can be identified.

4.12.1 Nursing competencies

Nursing must define its work in terms of the needs of the health, community and aged care sectors and within a framework that respects and values the work of other health professionals. With the change in service models in health and aged care, nursing must regularly review the essential competencies required to function safely and effectively. Nationally agreed competencies offer a strategic national framework for the education and training of nurses.

Education and training relevant to practice and delivery needs and standards and future development

Nursing education and training cannot be considered in isolation from the workplace and the changing needs of the health, community and aged care sectors. It is essential that education providers ensure that nursing education curricula and course content are relevant to current practice and delivery standards while at the same time building the generic competencies that provide the basis for future development. To achieve this, education and training initiatives must be monitored, reviewed and evaluated to ensure their continuing appropriateness and effectiveness, both for the short term and the longer term. A closer dialogue is required between the health, community and aged care sectors, the nursing profession and the education sector.

Changing clinical requirements and settings

Traditionally, hospitals have been major places for clinical preparation and the focus of research. These roles have been key to hospitals attracting and retaining high calibre professional staff. The changing role of hospitals and residential care facilities and the shift
Our duty of care to the community has important implications for nurse clinical preparation. Acute care hospitals will become inappropriate as the dominant context for the theoretical and clinical components of comprehensive undergraduate nursing programs. Neither will aged care facilities provide sufficient breadth of experience for the training of enrolled nurses.

Encouraging collaboration and partnerships
Collaborations and partnerships between the nursing profession, education and training providers and service delivery providers in the aged care and health sectors are essential to achieving quality education and training of nurses.

Multi-professional team approaches
A feature increasingly common in models of integrated and coordinated care is multi-professional team approaches to the provision of care to patients, clients and their unpaid carers. Models of education and training need to support multi-professional approaches to practice. Inter-disciplinary education is assisted by agreed practice standards for quality of care and partnerships between nursing and other health and social care professions.
5 An integrated national strategic direction

This chapter argues for greater national cohesion and visibility in the way nursing issues are addressed. We take the position that many of the challenges facing nursing cannot be met without strong and effective partnerships at all levels. Without a national whole-of-government approach endorsed by Commonwealth, State and Territory governments many of the links needed to move nursing forward cannot be established.

5.1 Removing barriers to improvement

Among the barriers to improving nursing care and resolving current difficulties are:

- the lack of long-term planning for the health workforce and nursing specifically
- the fragmentation of the responsibilities for different aspects of nursing and nursing education combined with the different contexts in which nurses work.

The lack of long-term planning is evident in the bust/boom cycles in nurse supply, the lack of consistency in the way data is collected on those who do nursing work, and the lack of visibility of nursing in national policy debate—even though it is a major contributor to health care. This lack of national cohesion is not surprising for a profession that practises in such a wide range of settings, receives its funding from various sources and is covered by State and Territory-based legislation and regulation. However, it is a barrier to developing a national approach to an area of expertise that is becoming increasingly sought after in the global market place.

Many issues related to nursing are dealt with in isolation from other issues that are contingent on or influence them. Two important examples raised throughout the Review demonstrate this fragmentation.

- The assumptions and arrangements that isolate education from practice create blockages to the resolution of difficulties. When conditions in the workplace are not attractive it is difficult to interest new entrants in nursing. Humphris synthesised this relationship as ‘practice is the limit to growth and the limit of quality’ (2002). The current practice environment is difficult because of shortages and poor workplace culture. Those factors create problems for the transition of new nurses and the education of student nurses. Even if there was a considerable increase in demand for education places, additional supply of nurses through education would be restricted by the capacity of the healthcare system to provide quality clinical experience.

- The lack of feedback systems between workforce needs and the education system, its funding and provision mean that there is no easy way for industry to influence decisions about the availability of education and training places. The current education and training system is based largely on demand from students. Public education and training providers, the largest providers of education and training for nurses and trained care assistants, must allocate positions in an environment of competing demands for other courses. The way education funding is allocated provides few incentives for the sector to respond to service industries like health. In the higher education sector, where specialisation in areas of research and teaching strength appears to be the emerging policy direction, nursing is unlikely to bring large amounts of non-government funding through commercial contracts or prestige to universities in the
way courses such as medicine and law do. Universities are likely to opt to attach teaching focus to research strength.

To overcome the barriers to improvement, we have given the recommendations in this report a national focus. They are also interlinked since the factors influencing nursing are both interconnected and interdependent. In this chapter, the recommendations encourage both immediate action and the establishment of structures and processes to provide national integration and ongoing planning.

5.1.1 Short-term plan
The focus of the short term is to respond to those recommendations that require immediate action and to establish an implementation task force to action, monitor and report on progress in relation to the implementation of the recommendations. The initial plan has the following elements:

• increasing the supply of nurses, both enrolled and registered
• improving access to and the quality of clinical education
• reviewing the regulatory/legislative and training barriers to effective and efficient use of the workforce involved in care work including the registered nurse, the enrolled nurse and the trained care assistant
• supporting the development of the nursing profession through education, leadership and research
• up-skilling care assistants to trained care assistants
• encouraging the retention of existing nursing staff, who are fundamental to the survival of nursing as a profession.

Since there are many stakeholders who will need to be involved in implementing the elements of this plan, the implementation task force will need to be drawn from across the health and education sectors and State, Territory and Commonwealth governments.

Recommendation 1—Implementation taskforce
Commonwealth, State and Territory health and education and training ministers should establish a national implementation taskforce to action, monitor and report on the progress of implementation of the recommendations.

Proposed responsibility: Commonwealth, State and Territory health and education and training departments

5.1.2 Long-term plan
The need for a national focus, a coherent voice on nursing issues, nursing leadership and recognition and affirmation of nurses were themes of the consultations and submissions. Many stakeholders, both individuals and groups, expressed a view that the appointment of a Commonwealth Chief Nurse would help these agendas coalesce. Despite the strength of the representation on this issue, there was recognition that, without credibility and a position of influence in Commonwealth Government policy processes, such a role would do little to promote nursing.

We concur with the need for a national coherent approach, for recognition and for strong leadership in nursing, but have taken a different view on the promotion of these matters. We are of the view that the appointment of a Commonwealth Chief Nursing Officer is a matter for the Commonwealth Health Minister and her department since a person in such
a role would be a government officer advising the Commonwealth Department of Health and Ageing and the Minister. Our proposal does not prejudice such a decision if the Minister wishes to make such an appointment. Indeed, we believe that all governments need systems that can provide expert advice on nursing issues, but that governments are in the best positions to judge what those systems should be.

While setting an initial direction in the work plan discussed above, the longer term vision requires the establishment of a body to provide that national focus, to bring all the stakeholders together to overview of the full range of issues related to nursing. We envisage such a body bringing together the considerable existing expertise at a national level, providing both the symbolism for the profession in terms of leadership, as well as developing leadership in nursing, promoting nursing and being a resource for government in planning health, community and aged care provision for the future.

While a national body will provide a structure to work through processes, there are three areas of strategy that form the framework for our other recommendations. The short-term work plan fits into these strategies, but the framework provides the long-term view of what we regard as the key issues for both today and the future. The three strategies are:

- building a sustainable nursing workforce
- maximising health outcomes through quality education
- capacity building.

The strategies are interdependent, so the recommendations in some cases form part of the platform for more than one strategy.

**Strategy 1: Building a sustainable nursing workforce**

The elements that will promote a sustainable workforce are as follows.

**Augmentation and retention of the current workforce**

The present problems in attracting and retaining nursing staff need to be addressed immediately. There should be a major investment in retention of the existing workforce, recruitment of nurses not currently employed in nursing, and recruitment from overseas.

Recruitment from overseas must be approached with sensitivity to the effects on the country of origin. There is considerable evidence, based on current demand trends and work arrangements, that the demand for registered nurses cannot be achieved through new graduates— even if there is unlimited availability of education and training places— because nursing now competes with many career options for a limited supply of new workers.

**Transition programs**

Transition programs provide the initial sustained exposure to the daily management and application of the theory learnt during the undergraduate course or VET program. The early days of employment are a time when the new graduate will decide whether they wish to continue as a nurse. Good transition programs are therefore an essential part of any strategy to maximise the community's investment in the education and training of the nurse by ensuring a safe and fulfilling transition from student to employee.
Skill mix and work organisation
Appropriate skill mix and investigations about how work could be organised more productively are necessary. The evidence suggests that current arrangements are not sustainable. This is not to suggest employers should substitute other workers for professional nurses where nurses are using their expertise to the best outcomes for patients and clients. Rather, we should examine the ways in which the different skills of different groups who form the team of people doing nursing or caring work can be best organised to ensure the optimum outcomes for patients/clients. Organisations also need to use the level of expertise and competency of each nurse and trained care assistant to maximise their job satisfaction and their confidence in the work or members of the nursing team.

Supply of nursing staff
A sufficient supply of all levels of nursing worker is important in building a sustainable workforce. A focus on only registered nurses will not result in the appropriate use of nurses in different settings or encourage the strengthening of career pathways from trained care assistant to the range of nursing careers available. Supply needs to be increased, particularly of enrolled and registered nurses. However, achieving this requires cross-government cooperation since the preparation of registered nurses is the responsibility of the Commonwealth and that of enrolled nurses and trained care assistants of the States and Territories. It will be a considerable challenge to deal with nurses and trained care assistants as an integrated unit in thinking about issues of supply.

Consistent data and a reliable evidence base
The availability of consistent data and a valid, reliable evidence base provides the platform for decisions on supply, skill mix and work organisation. Currently, the availability of consistent nursing workforce data is very limited. Understanding the interaction between the supply of different levels of nurse and trained care assistant in terms of the work that needs to be done is essential to making good decisions about work organisation and skill mix. Without that evidence base, decisions are often made on a limited view of what is efficient for the service provider—sometimes without much consideration of what is effective for the client/patient.

Strategy 2: Maximising health outcomes through quality education
To maximise health outcomes the following need to be addressed.

Training of care assistants
The education and training of care assistants is essential to the safety of the patient/client, as well as to their comfort. Ensuring care assistants can judge when to seek assistance from those with particular expertise, perform their work and understand their boundaries and limits is essential to delivering a system that achieves the best client/patient outcomes. While there is growing recognition of the need for appropriately trained care assistants, Australia has some way to go towards ensuring that all care assistants have an appropriate level of training and even towards understanding the nature and extent of their contribution.
Clinical education
Clinical education is an essential component of education and training for a practice profession. As such it is an important area to ensure the quality of education for new professionals and specialists. Ensuring the appropriate funding and building collaborative relationships are key elements to providing confident and competent new professionals and specialist nurses.

National education standards
Defining national standards for nurse education at all levels, including trained care assistants, and ensuring that appropriate quality assurance processes are established and maintained is important for ensuring the quality of the preparation of nurses and their assistants. Strong foundations developed through initial education and training provide the blocks on which educational pathways can be developed and career progression supported. These transitions between careers and educational levels will become increasingly important in the rapidly changing health services in which nurses work.

Flexible education programs
The capacity to develop and continue to evolve flexible and responsive education and training programs in the constantly changing environment in which health, community and aged care function is essential. Changes are occurring in many areas that influence nursing practice, from community expectations to highly sophisticated technology. With its broad professional base and range of competencies, nursing as a profession is in a unique position to respond to those changes. Only if nursing education providers are attuned to these factors and innovative in the preparation of new professionals and the development of experienced nurses will nursing be in the position to offer a potentially flexible, professional, cost-effective and responsive workforce to complement the range of other health professionals.

Strategy 3: Capacity building
The elements for capacity building include the following.

Nursing research
Nursing research and the development of nursing researchers provide the underpinning infrastructure for good decisions by policy makers and improvements in clinical nursing practice and education. As a new discipline, building up nursing research capacity is the key to better and more efficient health outcomes from nursing work. Applying the evidence to clinical practice will be an essential component of this development. Further, there will need to be ongoing research in the ways nurses are educated as new concepts of professional education and training are implemented.
Development of organisational knowledge and skills
Learning organisations need to develop the capacity to support and develop the knowledge and skills inside the organisation. Since the transfer of nursing education from hospitals, much of the supporting infrastructure for clinical nursing development has been lost. Clinical development of nurses can only be done well at the site of the expertise. Rebuilding and further developing clinical education systems in hospitals and the community and aged care sectors will provide the capacity for the services to build best practice and evaluation of practice into its systems.

5.2 Developing a collaborative partnership approach
Given the number of players with different responsibilities for diverse but intertwined elements of nursing, Australia will need to develop collaborative partnerships at all levels to resolve many of the difficulties nursing faces today, and to plan and respond to future challenges. At present there is little opportunity for this to occur in a way that interfaces all the different interests.

We believe it is in the national interest to promote arrangements that bring together Commonwealth, State and Territory health and education interests, nursing bodies, and the range of service providers, including government and non-government, that represent the different contexts in which nurses work.

5.2.1 Possible model
In proposing the following model, we recognise the enormous challenge a collaborative arrangement for nursing in Australia poses. We also note existing Commonwealth, State and Territory collaborative partnership arrangements. We note the advice that Kerka (1997) gives on collaboration and its requirements in proposing a national nursing council and collaborative partnership arrangements at State and local level. We seek endorsement from all governments to the establishment of a national nursing body, and their investment to enable the development of new or, where these already exist, the sustaining of existing partnerships. According to Kerka, investment is necessary as the success of collaborative partnerships requires:

- A shared vision of what is to be achieved, with agreed mission, objectives and strategies.
- An appreciation by all partners that a collaborative partnership is more than mere cooperation or coordination of efforts.
- Quality personal and professional relationships among the people in the participating organisations.
- True commitment to overcome barriers to make the partnership work.
- Open and frequent communication mechanisms, through formal and informal channels.
- A great deal of effort to develop and continuous attention and equal input from all partners.

We propose a national nursing council that brings together all the various interests in nursing and uses the expertise and, where possible, the resources of existing nursing and government bodies to the advantage of nursing and to promote future planning and
development. We expect the work of the council will draw together key elements that underpin our recommendations. These include:

- building nursing leadership
- promoting quality in practice and education
- initiating good practice in evolving models of care,
- ensuring a responsive profession by monitoring and responding to shifts in social attitudes and community expectations
- promoting an understanding of nursing workforce needs in terms of both supply and continuing education, particularly in areas of specialty.

Recommendation 2—Establish a National Nursing Council of Australia

Key to the development of Australian nursing is nursing leadership and national coordination. To achieve these outcomes:

a) An independent National Nursing Council of Australia (NNCA) should be established.
b) The body should be established, for five years in the first instance, to:
   i. provide national leadership in relation to nursing policies, education, training and practice
   ii. facilitate the work and activities of other nursing bodies
   iii. promote and facilitate consistency in nursing education, training and practice to improve the quality and safety of nursing care throughout Australia
   iv. develop and promote nursing leadership at all levels
   v. build capacity in the nursing profession and workforce.

c) The NNCA and its secretariat should be funded by Commonwealth, State and Territory governments with in-kind contributions from nursing organisations.
d) Membership should comprise nurse regulatory authorities, public and private sector nursing, nursing education at all levels, professional and industrial organisations, and representatives of Commonwealth, State and Territory health and education policy and funding organisations.
e) The Chair of the NNCA should be a nurse appointed by the Commonwealth, State and Territory health and education and training ministers.
f) It is not intended that the NNCA undertake work already effectively undertaken elsewhere and it is envisaged that, to pursue health, education and training outcomes, the NNCA should create appropriate links with other national and international bodies.

**Proposed responsibility:** Commonwealth, State and Territory health and education and training ministers, with details to be developed by the implementation taskforce
5.2.2 Links to existing bodies

There are many professional bodies that represent various nursing interests. Some are large organisations with broad briefs such as the Royal College of Nursing and the NSW College of Nursing. Others cover a specific field of nursing specialisation. Examples of the latter are the Australian and New Zealand College of Mental Health Nurses Inc (ANZCMHN Inc) and the Australian Council of Community Nursing Services (ACCNS).

The National Nursing Organisations (NNOs) are a coalition of 50 Australian national nursing organisations that have members in four or more States or Territories. Many of the bodies identified in the following discussion are members of the NNOs.

The Royal College of Nursing, Australia (RCNA) is a national professional organisation for Australian nurses. Its mission is to benefit the health of the community through promotion and recognition of professional excellence in nursing. The NSW College of Nursing is the only professional nursing membership organisation in Australia that offers a wide range of nursing courses at graduate level, particularly in NSW. It also caters for enrolled nurses, nurses returning to the workforce and overseas qualified nurses seeking employment in Australia. The Australian College of Midwives Incorporated (ACMI) represents the voice of midwives. Representing enrolled nurses is the National Enrolled Nurse Association (NENA). Its membership comprises enrolled nurses in all health settings from acute, subacute and rehabilitation through to extended and aged care. Other important professional and policy expertise lies with chief nurses/principal nursing officers who have formed an alliance.

The industrial structure for nursing is complex, as is evident from the different unions representing the nursing workforce and in the award coverage of nurses. While the unions are regarded as industrial bodies, they have in many cases an important and developing role in education both through VET coordinating arrangements and as registered private training providers. The Australian Nursing Federation (ANF), with branches in each State and Territory, was established in 1924, and is the national union most recognised in the coverage of nurses. Its total membership is 115,000.

The industrial arrangements related to enrolled nurses and care assistants vary between States and Territories. The ANF has some coverage as does the Miscellaneous Workers Union. Another union covering nursing is the Health and Community Services Union of Australia (HACSU) which has about 80,000 members working in every sector of the health and community services industries. In addition various education unions have an interest through the membership of nursing educators.

With these bodies, the State and Territory nursing registration boards (brought together nationally through the Australian Nursing Council Incorporated) have responsibility for protection of the public.

The Australian Council of Deans of Nursing brings together the interests of university nursing education. Broader education and training interests are also filtered through TAFE Directors and the Australian Vice-Chancellors' Committee.

Together these organisations and stakeholders have expertise that, networked and channelled to address national concerns, offers a major resource to policy makers and the healthcare system.
5.2.3 A local partnership approach
The National Nursing Council of Australia cannot stand alone but will require appropriate partnerships to develop at different levels to support different agendas. States and Territories will need similar local forums to reflect on State and Territory nursing issues and feed these to the Council to enable it to develop a national perspective based on local knowledge. In many States elements of such forums already exist.

Recommendation 3—Nursing education and workforce forums
State and Territory governments should establish nursing education and workforce forums to:

a) facilitate collaboration between the education sectors and the health and community and aged care sectors, including both the public and private sectors
b) address local and regional nursing education and workforce issues
c) assist with the implementation of the recommendations of this Review.

Proposed responsibility: State and Territory health and education and training departments

5.3 Regulation and legislation
While many nurses regard the current shortages as the main factor in the increase of unregulated care workers, this appears to be a simplistic view. In the aged care sector the growth of this group has displaced many enrolled nurses. Although, the inability to attract enrolled nurses because of reduction in training places may have influenced their availability, factors like financial constraints and the flexibility of the unregulated/unlicensed worker have resulted in the overlap of the scope of practice of these workers with that of enrolled nurses, particularly in aged care. In addition, supervision requirements and restrictions on the administration of medication make the enrolled nurse less flexible than the registered nurse.

There is a lack of consistency in legislative approaches in Australia in relation to scope of practice. Scope of nursing practice refers to that which nurses are educated, authorised and competent to perform. Chiarella (2001) examined the regulation of nursing and identified the full range of responses from jurisdictions that do not define scope of practice to defining it in detail. Two approaches are evident:

• a client/patient focused approach, where client needs are identified as paramount
• an approach that defines and protects professional boundaries

These two approaches are often reflected in whether the definition of the scope of practice is permissive or restrictive (Chiarella 2001).

The scope of practice of registered nurses and enrolled nurses is treated within a regulatory framework that requires nurses to meet particular competencies to be registered. There is no regulatory framework defining the scope of practice for trained care assistants.

Approaches adopted in different jurisdictions appear to reflect nursing practice within the culture of individual healthcare systems in Australia. Queensland has developed a decision making framework to support nurses' decisions on what fits within their scope of practice and Western Australia is using this model for some developments in this area. Other
jurisdictions such as NSW use the ANCI competencies as the set of minimum standards rather than defining scope of nursing practice.

As discussed in Chapter 4, the scope of practice of nursing has changed, demanding a shift in the professional role of nurses to one encompassing the functions of care-giver and the facilitative functions related to patient education, management, communication and research.

5.3.1 Factors influencing scope of practice
Scope of practice is influenced by many factors. The actual scope of practice of individuals is influenced by the settings in which they practise, the health needs of people, the level of competence of the nurse and the policy requirements of the service provider (QNC 2001). McMillan and colleagues (2001) identify contextual factors such as increased diversity in practice contexts, increased patient acuity in all nursing contexts, financial constraints, the legal and political climate, and consumer expectations. They conclude that, over the last two decades, there has been a shift in the usual practice for all levels of nursing, particularly registered nurses and enrolled nurses, with the practice of both amplified so that what was previously considered expanded practice has become the norm. Cross- and intra-professional boundaries have become blurred.

We recognise that this is a highly complex area, one that is predominantly the responsibility of the States and Territories, but it is an area of considerable frustration to those responsible for aged care in particular because it limits the best use of staff and reduces the status of enrolled nurses. While the impact of the range of legislative approaches in the different jurisdictions has largely been on enrolled nurses, the fragmented approach to developing the nurse practitioner role and the associated legislative/regulatory frameworks may have similar consequences for that role in the future.

The Senior Nurse Advisory Group, North Western Mental Health, summarised the more general frustration for nurses this way:

There have been significant advances in nurse preparation, yet legal frameworks, regulatory bodies and government policies have not recognised nor capitalised on the increased skill base. This has led to significant economic costs to the Australian community and personal costs. Nurses feel their skills are not being utilised and leave the profession in search of fulfilment elsewhere. (Response to the Discussion Paper).

5.3.2 Scope of practice—enrolled nurse
The Australian Nursing Council Incorporated (ANCI) report, An examination of the role and function of the enrolled nurse and revision of competency standards (2002a), provides an overview of State, Territory and New Zealand regulatory variation in relation to medication administration and related supervision of enrolled nurses. The consultants conclude that the role and function of the enrolled nurses with regard to supervision and medication administration varies both within Australia and in comparison with New Zealand (p. 14).

This same report makes the case for the displacement of the enrolled nurse, evident in the statistical trends (see Chapter 5), in this way:

It is ironic for the enrolled nurse that the trends in their role erosion emanate from different and contrasting skill mix models. Where some employers have sought to change nursing skill mix by including greater proportions of registered nurses, others have sought to increase the numbers of 'unregulated workers' ... Though in some states
studies are currently taking place, there is insufficient publicly available documented
evidence to what unregulated carers are actually doing and how this articulates with
the enrolled nurse role. Medication administration is however a particular feature in
this context, as unregulated care workers are not restrained by legislation in the same
way as enrolled and registered nurses.

(ANCI 2002a, p. 15)

A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions,
prepared by the Working Group on Aged Care Worker Qualifications of the National Aged
Care Forum highlighted many of the same issues put to us.

The Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions
(Working Group on Aged Care Worker Qualifications 2001) shows that there is broad
support for an enhanced scope of practice for enrolled nurses which would allow them to
administer up to and including Schedule 4 (S4) medication provided there is appropriate
education and supervision in a nationally consistent framework.

To achieve safe and effective medication management in aged care, the Working Group
suggested a number of strategies such as:

• developing a nationally uniform extended scope of practice for enrolled nurses in
  medication administration
• approaching the Department of Education, Science and Training (DEST) to develop
  traineeships for a vocational Certificate IV in Community and Health Services
• approaching nurse regulatory authorities in the States and Territories to accredit modules
  in the enrolled nurse curriculum to allow enrolled nurses to administer up to and
  including S4 medications
• approaching the State and Territory governments to amend legislation and policy where
  appropriate to allow enrolled nurses with appropriate education and training to
  administer up to and including S4 medications
• seeking the support of the Commonwealth Government in promoting an expanded
  scope of practice for enrolled nurses and a nationally consistent framework for enrolled
  nurse practice.

5.3.3 Future directions—guiding principles

There were strong representations to the Review that a new approach is needed to define
and regulate the scope of practice for different types of work settings and to require
training of care workers. The important attributes of this new approach were:

• responsiveness to change
• flexibility of workforce structure and work organisation
• a national approach and coverage.

Nursing must recognise the range of scope of nursing practice professionally, industrially
and educationally. Scope of practice must accommodate the breadth, range, extent, effect,
influence and reach of nursing activities and needs to be applicable to different practice
contexts. Ongoing review of the scope of nursing practice is essential because of the
changing context of care, changing patients’ and clients’ needs, and changing models of care.

Alternative approaches are available. In Australia, the Queensland Nursing Council (QNC)
has conducted much of the work on the scope of nursing practice. It commissioned
research into the scope of nursing practice and has published a Scope of nursing practice.
decision-making framework that defines the scope of nursing practice as ‘that which nurses are educated, authorised and competent to perform’ (QNC 2001, p. 5).

The Review supports the QNC approach of using a framework that sets out principles to guide decision-making on scope of practice. A decision making framework provides the umbrella under which regulatory, sectoral and professional standards can sit. It enables linkage of all activities undertaken to ensure the competency of nurses. A similar approach is being followed in New Zealand where the Nursing Council of New Zealand is developing a competency assurance framework for nurses (2001). In contrast, the push towards the development of competencies and standards for speciality areas by different professional bodies may lead to fragmentation, not to consolidation, and to confusion and unnecessary costs.

Development of the national framework for scope of nursing practice is a major priority given the foundation role it plays in nursing work organisation and planning. National leadership is required on these matters. We therefore recommend that one of the priorities for the new National Nursing Council of Australia is to gain agreement on a professional scope of practice model that allows for a flexible workforce structure and work organisation and is based on the principles set out in this report.

Recommendation 4—Nationally consistent scope of practice
To promote a professional scope of practice for nurses and greater consistency across Australia:

a) a nationally consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses

b) to facilitate this development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required.

Proposed responsibility: Implementation taskforce with the NNCA

5.3.4 Nurse practitioner

In Chapter 2 there is a summary of the developments in relation to the role of nurse practitioner in the different States and Territories. This information, combined with the more extensive material in Attachment 2.4, demonstrates that the progress has been slow and the approaches to the development of nurse practitioner have varied across the country. There is also considerable risk that, as the developments continue, the differences between States and Territories could create very different models once again fragmenting nursing.

While we hope the NNCA will be able to prevent such fragmentation occurring, we suggest that the first step towards a more cohesive national approach be the agreement on national standards for nurse practitioners. An agreed set of competencies for nurse practitioners would at least support an equivalent level of practice and the education required for the role. To assist with a more national approach, the Australian Health Ministers’ Advisory Council (AHMAC) should take an interest in this development as part of planning for a workforce that meets the needs of the health, aged and community care sectors. We believe that nurse practitioners offer considerable benefit to the aged and community care sectors as well as the acute sector and rural areas. The development of this level of nurse should be supported.
Recommendation 5—National standards for nurse practitioners

To promote a consistent national approach, the Australian Nursing Council Incorporated (ANCI) should be commissioned to establish national standards for nurse practitioners.

Proposed responsibility: Commonwealth, State and Territory health ministers

5.3.5 A national approach

Considerable advances have been made towards a national approach to regulation and legislation for nurses under the ANCI and following the mutual recognition legislation. However, as discussed in Chapter 2, there are still some major differences between States and Territories. These differences, along with other trends such as the globalisation of nursing, the capacity to offer courses through distance modes outside the usual potential education client group and the desire to be more unified as a body of nurses, mean that discussions of national course accreditation and nurse registration continue. There is considerable support for national accreditation of undergraduate nursing courses, and consistency of enrolled nurse preparation is of particular and strong concern, but the support for national course accreditation is not unanimous. Nor is the support for a national system of registration for nurses unanimous.

Clark (2001) identifies some of the issues associated with a national registration scheme. He suggests that the legal options for establishing such a scheme are limited. One option would be for the States and Territories to cede legislative power on nursing regulation to the Commonwealth, as was achieved with the Mutual Recognition Act 1992. He argues that, while this option may appear simple, in reality State and Territory jurisdictions would be ‘highly unlikely’ to cede their powers.

Taking a contrary view, Bryant supports national regulation. She argues that, although there are some similarities between the different Nurses/Nursing Acts, the lack of a single regulatory body has resulted in varying standards for all aspects of nursing and nursing regulation in Australia. As an alternative to the ceding of powers, she suggests an ‘agreement from all jurisdictions to develop a national template for the regulation of health professionals and amendment of all relevant legislation within an agreed timeframe’ (Bryant 2001, p. 51). Of interest in this regard is the recent agreement by the Commonwealth, State and Territory ministers responsible for training (ANTA MINCO) to develop model clauses for legislation to achieve agreed national outcomes in regulating vocational education and training (Campus Review 29 May–4 June 2002, p. 7).

We observed with some interest the recent developments for a nationally consistent medical registration model. Following the draft model for medical registration developed by the Australian Council of Safety and Quality in Health Care, a working party of the Australian Health Ministers’ Advisory Council (AHMAC) prepared a discussion paper, which was released in April 2002. The paper states that:

Recent developments, including growing advocacy in some sectors of the medical profession for the maintenance of professional standards and continuing professional development linked to registration, and increasing consumer expectations in relation to accessing information—suggest that the time is right to introduce some reforms in medical registration and it is preferable if these are nationally consistent. There is also a need to ensure nationally consistent registration and data to assist portability in the current mobile workforce and in response to developments in telemedicine. (Department of Health and Ageing 2002a, p. 1).
Australia should also take note of the findings of The Bristol Royal Infirmary Inquiry (cited in Leap & Barclay 2001). Leap and Barclay (2001) suggest these findings put a strong argument that the system of nursing regulation needs to ensure that health professionals acquire and maintain professional competence. To achieve this the Inquiry states that the system needs to include education, regulation, training, continuing professional development, revalidation and discipline. These observations are of particular interest in the light of the significantly different approaches between the States and Territories in relation to recency of practice for nurse re-registration (Chiarella 2001). We believe this disparity needs to be resolved in a manner that promotes an approach consistent with the professional nature of nursing and the principles of lifelong learning.

In giving consideration to the developments already in place across Australia and the challenges posed in establishing national systems of course accreditation and regulation, we have come to the view that nursing needs to build on the success of the agreements already in place by developing agreed principles that underpin the nursing legislative/regulatory framework in each State and Territory. We wish to affirm the requirement that for registration or enrolment nurses must meet the ANCI competencies. One of the important challenges for future regulatory frameworks is that of ensuring that those who are registered to practise as nurses, at whatever level, are competent and current in their practice. For this reason indicators of current competence should be essential components of the agreed principles. In making the following recommendation, we believe that there will continue to be developments in this area and consider that the NNCA will need to continue to address issues related to consistency in legislative/regulatory approaches and the underpinning quality systems, such as the accreditation of courses.

Recommendation 6 — National ANCI principles to underpin nursing legislation and regulation

To ensure a more nationally consistent approach to nursing, State and Territory nursing legislation and regulations should be underpinned by nationally agreed principles. These principles should include requirements for:

a) assessment against the ANCI competencies for initial registration of registered nurses and enrolled nurses

b) audited self-reporting for continuing registration of registered nurses and enrolled nurses using indicators that demonstrate currency of competence including ongoing education.

Proposed responsibility: ANCI in consultation with the NNCA

5.3.6 Care assistants

With regard to the regulation of workers who are carrying out care work, whatever their title, there was strong support for:

• mandatory training for all workers ‘undertaking nursing work’ with identified appropriate qualifications for different levels of work

• the minimum level of qualification for those involved in direct care of clients/patients to be Australian Qualifications Framework Certificate III

• articulation of Certificate III training with enrolled nurse programs to allow for career progression.

The Health and Community Services Union, in their response to the Discussion Paper, recognised the ‘increasingly significant role’ that care assistants are playing in assisting nurses with the provision of health care. However, the Union also stated that:
A new approach is required, an approach that requires a more stringent training regime and an expectation that defined standards of care are being delivered, and guidelines, which spell out the parameters, (i.e. limitations) on the role of carers.

Protection of both the public and the worker are important for the progression of a system of care that is both viable and responsible. This protection is becoming even more necessary as demands for support in personal care increase due to population ageing. There were mixed views on whether there should be regulation of care workers. Some organisations suggested that regulation would ultimately result in another layer of worker replacing the group that has been regulated. This is a most complex issue, but it is one that needs resolution if an appropriate skill mix in the different settings of care is to be implemented.

While we take the position that the regulation of care workers may not be the best approach in this instance, we believe that employers have the responsibility to ensure that:

- appropriate suitability checks are made
- care workers undertake only tasks for which they have the appropriate level of training and skill
- care workers have appropriate supervision for the work they are undertaking.

Throughout the Review we received various suggestions about care workers from different groups on how we could achieve better outcomes in this regard.

- The Queensland Nursing Union advised us that they supported a similar model to the one proposed in the Queensland Child Care Bill and Regulation (for more detail see Attachment 5.1). The draft Bill and Regulation sets out employer record keeping obligations. These include the requirement that people working in child care services have suitability checks, and that the licensee of a child care service must keep originals or certified copies of the suitability notices of their staff as part of their records. The draft Bill also contains requirements that role statements are prepared and maintained in regard to positions in the child care service.

- Other suggestions included using the established licensing processes to require that the workforce involved in caring work have appropriate training and checks. States and Territories have various mechanisms in this regard for hospitals, both government and non-government, and there are licensing mechanisms or service contracts for aged and community services.

- Another alternative is to establish a system of credentialing workers who meet a given set of requirements, thus making them easier to identify and possibly more attractive to employers. This system would be costly to workers who are not well paid and who are often casual workers (including nursing students) and is not one we support for this reason.

As a nation, we need to ensure the protection of the public, especially those who are particularly vulnerable due to disability. This requires a system that provides the appropriate infrastructure to ensure employers take responsibility for the skills of the staff they employ for the work they are expected to undertake. We suggest that the States, Territories and the Commonwealth, in association with local governments, encourage employers to meet these obligations by introducing a system that involves one or both of the following:

- including certain requirements in either the licensing or service contract arrangements for different services
- introducing a regulatory system like the one proposed for Queensland child care services.
An agreed framework across all governments that addresses the use of care assistants and the protection of the public would prevent a new level of fragmentation in an area that affects the work of nurses.

Recommendation 7—Care workers not covered by regulation
To ensure quality and safety in the health, aged and community care sectors, all workers without relevant recognised training who are employed to provide direct care should have:

a) a common national nomenclature
b) a minimum competency level of Certificate III from the appropriate Community Services or Health Training Package
c) an appropriate suitability check.

As a matter of urgency, the Commonwealth, States and Territories should establish or utilise an appropriate system to ensure that compliance in relation to the minimum qualification and suitability checks for care assistants is achieved by 2008.

Proposed responsibility: Implementation taskforce

In Chapter 8 we propose that, as part of the response developed to meet the proposed competency requirements for care assistants, the development of systems that recognise prior learning and current competency for the vast number of experience care assistants should be implemented.

5.4 Investment in nursing
The lack of Australian literature reported in the commissioned reviews indicates that nursing research has not been a priority area in the past. We are of the view that improvements in nursing education and practice will rely on developing an evidence-based culture in nursing. This in turn will need to be supported by relevant research in the Australian practice and education context as well as the development of skills in undertaking research and interpreting and applying research findings.

The size of the nursing workforce ensures that nursing has an important effect on the quality and effectiveness of health services. Despite this, there is little research on nursing. Perhaps this is unsurprising given how integral nursing is to the functioning of healthcare systems—about which there is also a lack of knowledge and research (Stilwell 2002). Both areas are only now becoming the focus of research. Evidence from the United States and Canada concerning the effects on patient outcomes and efficiency of the healthcare system suggests that decisions about work arrangements and nursing skill mix have implications for both of these areas. The findings of this overseas research, while important, are also contextually bound and should not be directly applied to the Australian situation without checking on the transferability to our system. Australia has limited knowledge about what nurses actually do, a small but growing body of nursing clinical research, and limited data on the nursing workforce.

University nursing faculties will need to play an important role in developing nursing. Their effectiveness in doing so will rely on their ability to capture research training places and research funding. The current highly competitive research funding environment is not favourable to a new discipline such as nursing. The new system of funding announced in 1999 in Knowledge and Innovation (Kemp 1999), a policy statement on research and
research training, was designed to encourage higher education institutions to develop a strategic portfolio of research activities and to align research training opportunities with the universities' research strengths. It will be necessary to provide some initial support to such a relatively new discipline as nursing to ensure that it is able to compete on an even basis with other disciplines long established in universities.

In the development of the discipline of nursing the following comment is instructive of the importance nurses place on research:

> The main issue in regard to the consolidation and expansion of quality nursing research by clinical practitioners, academics and researchers is one of funding. Without targeted and prioritised funding for nursing research that is clinically relevant then it is impossible to progress this agenda quickly. In addition, pilot funding should be prioritised towards those universities and health industry partners that have demonstrated a clear track record of collaboration and clinical research outcomes.

(Sir Charles Gardiner Hospital, response to the Discussion Paper)

The paucity of information and the challenge to evaluate and apply what is available about nursing affects the considerations of policy and planning for a viable workforce. Anecdotal evidence in Australia also indicates the need for structured, systematic processes to assist nurses to incorporate the latest evidence into policies, procedures and practice.

The transfer from research findings into practice remains a challenge. Practice should be based on current best available evidence drawn from both quantitative and qualitative research methods. To ensure integration into nursing practice funding for the continuation and further establishment of nursing research centres and research projects is essential.

5.4.1 Research (clinical, policy and education)

The Commonwealth Government funds two research councils that provide research grants with relevance to nursing. It also funds the National Institute of Clinical Studies Ltd. The National Health and Medical Research Council (NH MRC) has primary responsibility for supporting health and medical research in Australia. The Australian Research Council (ARC) also provides some limited support for health and medical research; however, it is specifically precluded from supporting research in clinical medicine, dentistry or public health research. The National Institute of Clinical Studies, only recently established, is to provide a national, integrated focus for work undertaken to continuously improve the quality of clinical practice and its delivery to patients. Additional material on these bodies is at Attachment 5.2.

Considering the size of the nursing workforce, the cost of providing nursing care and the number of students in universities studying nursing, the amount of funding going to nursing research (whether it be clinical, policy or education research) is small. One indicator is the amount of money going to nursing research from the NH MRC budget. Only five of the 758 project grants funded by the NH MRC under the continuing grants in 2000 were designated as being for nursing research. Commenting on the lack of research funding in the areas of aged care, a sector largely supported by nursing work, the report Recruitment and Retention of Nurses in Residential Aged Care for the Department of Health and Ageing states:

> Research funding bodies such as the NH MRC have consistently failed to fund such endeavours, as their practical, applied focus does not coincide with the focus of the existing research funding bodies. A nationally competitive research funding scheme would promote research activity in the sector, increase evidence to improve care and increase the status of aged care nursing.

Of note in the management of the different research programs is the development of research priorities and the definition of the proportions of funding to be allocated to these priorities. The priorities are often of a highly technical nature and focus on areas considered prestigious and likely to bring overseas investment into the country. While not questioning the importance of these research investments, it is important that governments recognise that there is considerable investment in the nation’s health care, a key Australian industry. Research into nursing and the work of nurses is necessary to enable appropriate policy and practice decisions that will protect that investment and ensure the best social outcomes and ensure the effectiveness and efficiency of the healthcare system.

5.5 Research Training Scheme

The Research Training Scheme (RTS) is important for the development of new researchers. The allocation of higher degree research places to institutions is made on the basis of performance under this scheme. A performance-based formula distributes places across universities based on successful research completions (50 per cent), research income (40 per cent) and research publications (10 per cent) (DEST 2002a, p. 123). Until 2004 there will be special arrangements to protect institutions from any major funding losses.

Universities offering nursing are generally among those with high proportions of undergraduate students and lower numbers of higher degrees by research. These universities will not have high numbers of completions of higher degrees by research in coming years. Consequently their performance will rank poorly in comparison with other universities with high numbers of research students. Nursing faculties are often situated in universities with an overall low ranking on research performance. Twelve of the universities offering nursing had less than 3 per cent of their students undertaking higher degrees by research in 2001. This compares unfavourably with the top three universities that had greater than 10 per cent of students undertaking higher degrees by research. None of this latter group offers nursing (DEST 2002a, p. 171).

The numbers of non-overseas nursing commencements of higher degrees by research ranged between 92 and 109 between 1996 and 2000, and the number of completions per year across the 1996 to 1999 ranged from 21 to 30. Within the broad field of health, nursing accounted for 34 out of 727 of the higher degree by research completions for all students (includes overseas students). On the basis of recent trends, a performance-based system will disadvantage nursing, particularly if universities choose to distribute research training places internally on a performance basis. There appear to be few incentives for universities to do otherwise, since nursing is likely to attract little external funding through contracts for research compared to other disciplines.

5.6 Strategies to develop capacity

A number of possible strategies could be undertaken to develop a strong nursing discipline and research base. All will require some investment in capacity building, but the Commonwealth is not the only party with an interest in ensuring the development of research capacity in nursing. State and Territory governments and other employers also have an interest. We have targeted two areas to develop this essential capacity: the Research Training Scheme and dedicated funding for research grants and the development of cooperative research centres.
While we acknowledge the competitive funding environment, we propose that the Commonwealth with the States and Territories should examine how best to provide support for the establishment of a number of nursing research centres with research grants to support their work, and in addition to provide grants to encourage research in strategic nursing areas outside those of the research centres. More detail of the possible costings associated with our proposal is at Attachment 5.3.

Recommendation 8 — Research and research training for nursing
To build capacity in a vital discipline that has only been in the university sector for a relatively short period:

a) immediate steps should be taken to ensure that the current level of postgraduate research scholarships and research training places for nurses are at least maintained, with the longer term target of doubling Research Training Scheme (RTS) commencement load by 2008.

Proposed responsibility: Implementation Taskforce and Department of Education, Science and Training

b) a dedicated pool of funding from new or existing sources should be made available over the next five years to provide research grant money and for cooperative research centres for nursing.
   i. particular priority should be given to building longer term capacity and integration of research findings into practice
   ii. priority areas might include evidence-based practice, aged care, work organisation, mental health nursing, and nursing in rural and remote areas.

Proposed responsibility: Implementation taskforce
6 Nursing careers

This chapter explores a range of issues related to nursing careers. It examines strategies to raise the image of nursing and what is needed to attract people, particularly from under-represented groups, to consider nursing as a career. What opportunities does a nursing career offer? What are the pathways available within nursing careers? What transition mechanisms are available to help nursing students transfer to the workplace, to re-enter or to transfer between different levels of nursing?

The Review commissioned research specifically on this issue, The Nursing Career Pathways Project (Price, Heartfield & Gibson 2001), and the information contained in this section draws heavily in parts on that research.

6.1 The image of nursing

Media attention on nursing and the nursing profession is usually industrially focused and can be negative. During the course of this Review, we were continually pressed to market a positive image of the nursing profession, one which encompasses all its members (enrolled nurses, registered nurses, nurses in various speciality areas, nurse educators, nurse managers and nurse practitioners).

In an article in September 2000, the Dean of the School of Nursing at the University of Washington discussed the image of nursing that had been perpetuated over time as being one of manual labour mostly performed by women, and likened it to motherhood ('an essential but unpaid contribution to the work of society, with rewards that are largely intrinsic to the job'), and said that this misconception of nursing was perhaps the root of the present nursing shortage (Wood 2000).

As Wood outlines in her article:

Moreover, the faces behind the touching hands have changed. Today's nurses are increasingly male, increasingly from diverse ethnic backgrounds, increasingly drawn to nursing from other professional careers they come to nursing school because they want to make a difference in the world, and they leave with the tools to do just that ... Nurses in the 21st century perform critical services at every level of need. Nurses help families learn to care for children who are able to live at home with serious health problems, sometimes requiring the use of complicated breathing equipment. Nurses who practice in hospitals make life-saving decisions and detect possibly fatal complications. Nurses in community health make changes in the community to benefit entire populations, some by instituting changes in public policy ... In these and hundreds of other ways, the work of nursing has deep intellectual and scientific roots. In addition to the many practice roles of modern nursing, today's nurse scientists also make important contributions to health care research that are not widely known or appreciated.

In the Nursing Career Pathways Project (Price et al. 2001), the authors refer to the fact that the diversity offered by careers in nursing is one of the profession's greatest strengths and should be promoted. A comprehensive nursing degree for registered nurses and the recent developments in the diversification in the preparation of enrolled nurses enable nurses to obtain employment in a wide and varied range of locations, including:

- Australian and overseas geographical settings
- metropolitan, rural, regional and remote settings
• residential care facilities
• rehabilitation practice settings
• acute care and day surgery hospitals (adults and children)
• community centres
• neighbourhood housing
• school health facilities
• health industry/health focused business settings
• university, vocational, and school educational settings
• maternity/birthing facilities.

6.1.1 Marketing nursing

Much is being done across Australia by different government and non-government organisations and groups to promote nursing in order to encourage people to consider nursing as a career (see Attachment 6.1). A number of State health departments have undertaken successful nurse marketing campaigns in the past few years, such as Western Australia’s Are you Good Enough to be A Nurse? campaign or the South Australia’s Nursing Takes You Places campaign, and the more recent Victorian Government’s advertising campaign aimed at attracting nurses back into Victoria’s public hospitals.

In submissions and responses to the Review’s Discussion Paper, there was clear support for an active integrated marketing campaign, which would address nursing shortages, but which would also be aimed at highlighting the diversity in a nursing career and the possible career pathways into and out of the profession. By doing this, it is hoped to attract school students and others into nursing, to encourage nurses who have left the profession to return, and to help retain the current nursing workforce. There was a call for a well-planned professional marketing campaign that strategically targets specific groups. As one respondent noted:

Successful marketing of any service demands a professional approach by a professional group whose expertise has been demonstrated by results. It would seem inappropriate for any nursing organisation to undertake this on the basis that they are an organisation. It has been shown to be valuable in Western Australia to conduct campaigns aimed at attracting and retaining nursing staff so creative campaigns incorporating career materials are useful and successful as has the reality television shows depicting real life nurses in situations that reflect their expertise, knowledge, perception and understanding. Nurses are always well thought of by those who encounter the system and information on career pathways should be developed that accurately depicts the contribution nurses make to society and the sacrifices they endure in order to do so.

(Catholic Health Australia, response to Discussion Paper)

There is certainly an identified need to promote a positive image of nursing, and the different mechanisms for doing this nationally should be planned strategically with professional marketing advice. Considering the highly successful campaigns in the different jurisdictions, we do not propose a national campaign at this time. The proposed National Nursing Council of Australia (NNCA) might profitably explore how to bring together these different nursing campaigns in a way that will be the most cost effective and meet local variation.
Recommendation 9—The image of nursing

To develop and improve the image of nursing:

a) the value, contribution and benefits of a nursing career should be promoted

b) expert advice should be sought to develop a national marketing profile (brand) for nursing:

   i. the profile should help generate a broader base of recruitment to nursing which reflects the diversity of the Australian population

   ii. the profile should be used by States and Territories, the universities, the vocational education and training sector, career counsellors and others concerned with recruitment and retention.

Proposed responsibility: NNCA with advice to governments and other employers

6.1.2 Nursing information and careers promotion

The Australian community has embraced the Internet enthusiastically and the majority of key stakeholders in the nursing community have developed comprehensive websites with information about nursing. An integrated national professional nursing website to provide information on a range of nursing issues would promote a positive image of nursing. The website could link to relevant National, State and Territory sites across Australia, including Commonwealth State and Territory health and education departments, nursing registration authorities and various Australian nursing organisations. We support the concept of a web-based portal to promote the nursing profession and to draw together the wide range of quality nursing information available on the Internet.

Careers information must be readily available and marketed to potential nurses, the community and the existing workforce. Submissions and comments noted the apparent lack of comprehensive up-to-date careers information in schools about nursing, and suggested that more work was needed to raise the profile of nursing to young people to encourage them to consider a career in nursing. Indeed, in their research project, Price and colleagues (2001) conducted a search of a range of careers and government authority websites on nursing careers information and found a level of invisibility.

The Commonwealth funds a range of career information projects, principally the Job Guide and the soon-to-be-released, Internet-based, National Career Information System (NCIS). The Career Education Section and Career Information Section of the Commonwealth Department of Education, Science and Training indicated to us that they would be pleased to provide advice and would also facilitate the creation of appropriate links with the NCIS.

There are a number of strategies and initiatives that could be developed in a coordinated manner to promote a positive image of nursing and the nursing profession in Australia. This could include marketing campaigns, a coordinated web-based portal and other proposals to raise an awareness of nursing in careers information. This is a matter best progressed by the NNCA in consultation with all stakeholder agencies and nursing bodies.
Recommendation 10—Information on nursing
To provide coordinated and ready access to information on nursing to the public and other stakeholders, the NNCA should:

a) maintain an information base of recruitment and re-entry programs, assessments of their effectiveness and advice on best practice

b) develop a web-based portal for Australian nursing.

Proposed responsibility: The NNCA

Accordingly to Price and team (2001), there was also misclassification of nursing in some key career publications. For instance, they claim that nurses were classified in Department of Employment, Workplace Relations and Small Business material as a group of para-professionals, at variance with the Australian Standard Classification of Occupations (ASCO) classification of nursing as a profession. This lack of visibility and misclassification in nursing careers publications should be quickly addressed by governments to ensure their reference to nursing occupations is consistent with ASCO and reflects the professional status of nursing.

Recommendation 11—Government and employer information on nursing
To ensure that nursing is portrayed as a profession in government and employer information, all levels of government and other employers of nurses should:

a) review their recruitment and promotion activities to ensure they reflect the professional status of nursing and the valuable social contribution made by nursing through its diverse roles and practice

b) review their classification of ‘nursing’ to ensure it is consistent with the Australian Standard Classification of Occupations (ASCO) classification, in order to reflect the professional status of nursing.

Proposed responsibility: Commonwealth, State and Territory governments, and other employers of nurses

6.2 Attracting different groups into nursing

Education providers, health agencies and government initiatives are doing much to attract people from a wide range of backgrounds into nursing by recognising and addressing the particular challenges faced by the different groups. Nursing should make attracting men to the profession a priority. In seeking to do this it might well research how the airline industry has been able to change the profile of what used to be largely a role for female to the more gender neutral role of ‘flight attendants’.

6.2.1 Rural and isolated nurses

Commonwealth, State and Territory health departments have all developed initiatives specifically for nursing students residing in rural and remote areas, or otherwise initiatives to encourage students to consider nursing in those areas. They also offer other scholarships either specifically for nurses or for nursing students that can also be accessed by nurses working in rural and isolated places (see Attachments 6.1 and 6.2).
Education programs have been designed specifically for rural and remote area nursing, such as the Remote Health Practice Program at Flinders University and the Centre for Remote Health, Alice Springs and the Postgraduate Program in Applied Health Science (Rural and Remote). It is interesting to note the lead these programs are taking in the area of interdisciplinary education.

We also note and support the rationale behind the current National Rural Health Alliance project, Action on Nursing in Rural and Remote Australia (CRANA, AARN & ANF 2002), which aims to set out a five-year plan for the way nurses work in rural and remote areas.

**National Rural Health Alliance Project—Action on Nursing in Rural and Remote Australia**

The National Rural Health Alliance (NRHA) is the peak national body working to improve the health of Australians living in rural and remote areas. The Alliance comprises member organisations, each of which is a national organisation in its own right. The 21 represent both the consumers of health services and the health professionals providing service to non-metropolitan areas.

As part of the Action on Nursing in Rural and Remote Australia project, three documents were developed for public consultation.

The Issues Paper, recently prepared by a number of its member organisations in conjunction with the Australian Council of Deans of Nursing, the Australian Nursing Council Inc. and the Royal College of Nursing, provides an overview of the challenges facing nursing in rural and remote areas. The paper explores many issues in common with the National Review of Nursing Education, but specifically in the context of working rural and remote areas issues such as scope of practice, advanced practice, nurse leadership and management, models of care provision, the impact of workplace environment, the image of nursing in rural and remote areas, workforce planning, and educational requirements.

The Issues Paper sets out recent initiatives across all jurisdictions in relation to nursing in rural and remote areas. It raises the concern, however, that initiatives are not developed with any coordinated national approach, and that a more integrated strategy is needed to deal with rural nursing education and workforce issues.

The other documents in the Project are a Vision and Required Conditions document and a Key Recommendations for Action document. These set out a five-year plan for the way nurses work in rural and remote areas and how they are managed and supported and utilised in the workplace, with an emphasis on multi-disciplinary teams of health professionals from various fields adequately prepared and supported to work in rural and remote practice. All three documents were made available for comment to June 2002 on the NRHA website at [www.ruralhealth.org.au](http://www.ruralhealth.org.au). A number of events and activities are planned as part of this project, but the Project Organising Committee indicated that the first major face-to-face event will be held after the release of the report from the National Review of Nursing Education.
6.2.2 Students from diverse cultural backgrounds

A research project undertaken for this Review, Nursing Education in Multicultural Context (Eisenbruch et al. 2001), surveyed universities and schools of nursing on their approaches to the multi-cultural context of education. Many of those surveyed reported on a range of strategies they had put in place to attract culturally diverse students into nursing, including language support, the inclusion of different cultures in promotional materials, and cultural support or study centres. However, many faculties also noted that recruitment issues relevant to students from multi-cultural backgrounds were common to all potential nursing students, and would best be addressed by raising the profile of nursing as a worthwhile career choice.

When examining the multi-cultural diversity of the Australian nursing workforce, Eisenbruch states:

A glimpse at the diversity of the Australian nursing workforce is provided through a sample of data collected by the NSW New Graduate Recruitment Consortium in Sydney. This Consortium provides a service that places new graduates in nursing positions. All Area Health Services in the State participate. Using data collected over a four-year period (1997-2000), results show that an average of around 330 applicants per year (18-20% of total applicants) speak a language other than English. Approximately 20 per cent speak a second language, the most common during these years being Tagalog, Mandarin, Hakka (Chinese) and Spanish. Between 12 and 14 applicants each year are fluent in Sign Language.

(Eisenbruch et al. 2001)

There are some challenges in promoting nursing to some cultural groups. Many parents from different cultural groups (such as Greek, Middle Eastern and Vietnamese communities) consider that nursing lacks status as a profession.

Given the diversity of background of many Australians, it is unfortunate that students from multi-cultural backgrounds are not proportionally reflected in student numbers. As one respondent to the Review Discussion Paper noted:

Given the multicultural nature of Australia generally, and the fact that already 1 in 4 older people are from culturally and linguistically diverse backgrounds, it will be important to actively and positively promote nursing as a career in such communities. Other innate skills (such as language and cultural understanding) that workers from culturally and linguistically diverse backgrounds would bring to nursing will be beneficial to acute health as well as to aged and community care services.

(Aged and Community Services Australia, response to Discussion Paper)

Different government and educational institutions are undertaking initiatives to address issues surrounding their multi-cultural employees. The Eisenbruch report (2001) cites an example from the South Eastern Sydney Area Health Service, which began the Bilingual Human Resource Project in mid-1999 to increase the appropriate and effective use of language skills of mainstream staff within the Area Health Service. 32.7 per cent of whom were identified as speaking a language other than English. While some strategies are evident for achieving a representative cultural mix, we note that there is little government action in this area compared to initiatives for rural students and Indigenous students.
6.2.3 Indigenous students

We heard considerable debate about the difficulty of retaining Indigenous students in nursing education. The Commonwealth provides funding support for Indigenous students through a component of operating grant allocated to the Indigenous Support Funding program to meet the special needs of Indigenous Australian students and to advance the goals of the National Aboriginal and Islander Education Policy. In 2001 funding of over $23 million was provided for a range of activities including the establishment of Indigenous Education/Support Units, assistance with study skills, personal counselling, and cultural awareness activities (DEST 2002a, pp. 90–92). There are also nursing scholarships provided by States, Territories and the Commonwealth, either specifically for Indigenous students or which can be accessed by Indigenous students (see Attachments 6.1 and 6.2).

The Review has noted the work of the Indigenous Nursing Education (INE) Working Group which was established by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in 2000, and includes representation from the Congress of Aboriginal and Torres Strait Islander Nurses and the Australian Council of Deans of Nursing. In November 2001 this group produced an Issues Paper and Strategic Framework Indigenous Health in Core Nursing Curricula, and the Development of Recruitment and Retention Strategies (OATSIH INE Working Group 2001) as a consultation draft. The report of the Indigenous Nursing Education Working Group is currently being finalised.

In May 2002 the Australian Health Ministers’ Advisory Council endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. One of its objectives is the need to increase the number of Aboriginal and Torres Strait Islander people working across all the health professions, including nursing. An Aboriginal Health Workforce Working Group will progress the objectives of the framework.

We support the continuation of the work of the Indigenous Nursing Education Working Group, and the planned Aboriginal and Torres Strait Islander Health Workforce Working Group, in efforts to improve the recruitment, retention and support of Indigenous Australian nursing students.

We also note the work of many other groups, educators and employers who have worked together to develop innovative courses to assist Aboriginal and Torres Strait Islander students access training and to have exposure to the working environment. We considered the following case study of an initiative of the Booroongen Djugun Aboriginal Corporation to illustrate how these type of programs can be managed.
Booroongen Djugun Aboriginal Corporation

Booroongen Djugun Aboriginal Corporation is a specialised venture which incorporates an aged care facility, a training college, and centre-based and outreach community service programs.

The Booroongen Djugun College is a registered training organisation that conducts industry-approved, nationally recognised courses. The courses have been developed especially for Indigenous students and are conducted on the College's Kempsey campus and also at other centres throughout New South Wales. Linked to the College is Booroongen Djugun Aged Care Facility, a unique facility situated in Greenhills, on the Mid North Coast of New South Wales. It was established to provide care to Aboriginal frail aged, aged and people with a disability, who could not be cared for in the community. Its services have been extended, as a result of the high demand for aged care in the Kempsey area, to also provide high-quality care to non-Aboriginal people.

In linking the two arms of Booroongen Djugun together, students can have classroom training linked to hands-on practice in a structured workplace environment which is connected to the spiritual feelings of Aboriginal people.

Outreach training is also available through the College. For instance, in 2001 85 students were enrolled in the College's Newcastle branch. Courses offered were Certificate III in Community Services (disability work), and Certificate IV in Aboriginal Health and Torres Strait Islander Health. The VET in schools program combines studies for the Certificate III in Community Care Services with hands-on training at the College's aged care facility, Macksville Hospital and within the College itself. Students from Years 10–12 attend Booroongen Djugun College one day a week while undertaking the Certificate III course.

<www.booroongencollege.nsw.edu.au>
6.3 Career pathways

Nursing career pathways need to identify the diversity of nursing roles, and what is expected of them in terms of the education, training and employment needs of the different nursing groups. Price and colleagues (2001) suggest that career pathways for nursing need to be structured in such a way that they demonstrate the diversity within nursing not only to nurses and those interested in nursing as a professional career, but also to educators, policy makers and the wider community. Nursing career pathways need to incorporate choice, recognise skill development, and provide a framework to set out the goals and strategies to achieve them. They need to be flexible to accommodate individual life experiences, access to information, personal decision-making and emergent changes to health care systems. They need to be responsive to health care needs and contribute to health outcomes for all Australians, and incorporate and respond to Australia’s cultural diversity.

The authors propose a framework for developing nursing career pathways which includes the following elements:

- Nursing practice roles (both clinical and non-clinical) demonstrating how the scope of nursing practice involves different roles
- Employment opportunities
- Qualification requirements
- Ongoing learning options
- Registration requirements
- Nursing classifications
- Integration of nursing practice with other healthcare professional practice
- Diversity of educational practice placements

(Price et al. 2001)

6.3.1 Education pathways

Pathways tend to suggest a fairly linear progression. One way of mapping the alternatives open to nurses, which was suggested during the Review, is to conceive of options as being part of a careers matrix. These matrices should set out the numerous entry points into nursing studies, credit arrangements for previous experience, and articulation into other courses that provide access to related careers. The construct of matrices does not limit the discussion to nursing occupations only, but encourages the links to other related occupations to be explored.

We met a number of people who had already made their own path through different parts of the system or who were planning to do so, including one nurse who started as an assistant in nursing and was undertaking a Masters of Midwifery degree. Others had completed Certificate III, had been working as assistants in nursing and were training to become enrolled nurses. Many enrolled nurses were undertaking courses to become registered nurses.

Credit for experience and previous study is a developing feature of nursing education in Australia. Increasing numbers of universities give some credit to enrolled nurses who undertake pre-registration nursing courses. Access to a nursing career through a range of entry points increases the opportunity for some groups and individuals to become nurses. For example, lower socio-economic and Indigenous Australians may be better able to access a career as a registered nurse through a pathway beginning as an enrolled nurse or through one that starts as a trained care assistant with articulation into enrolled nurse preparation.
as demonstrated in the Tripartite Agreement (for Indigenous Students) between Illawarra Institute of TAFE, Illawarra Area Health Service and the University of Wollongong.

Tripartite Agreement—Illawarra Institute of TAFE, Illawarra Area Health Service, University of Wollongong

The Tripartite Agreement between the Illawarra Institute of TAFE (Shellharbour Campus), the Illawarra Area Health Service and the University of Wollongong provides an educational pathway for Indigenous students interested in a career in nursing. The program is loosely called 'The Tripartite Agreement' because of the involvement of the three organisations. Prospective students are initially recruited by the Aboriginal unit within Shellharbour College of the Illawarra Institute of TAFE/Nursing Studies, or alerted to the course by other forms of marketing such as community radio or word of mouth. Students then complete a basic health course at TAFE, which introduces the student to Anatomy and Physiology and other health-related subjects including First Aid.

Following successful completion of the introductory course students may apply to Illawarra Area Health Service for entry into the enrolled nurse program offered at Shellharbour College of TAFE. If successful in gaining entry to the program the Illawarra Area Health Service employs them during their studies and on successful completion of the enrolled nurse program students are offered employment for a period of two years as an enrolled nurse. Following the two years employment period with the Service the enrolled nurse may apply to the University of Wollongong for entry into the undergraduate nursing program (Bachelor of Nursing). The student can negotiate for advanced standing on admission.

Following successful completion of the Bachelor of Nursing program, students are offered two years employment as a registered nurse by the Illawarra Area Health Service. Support is given to the student throughout the program.

An advantage of the program is that participants can enter it at any level: Aboriginal Community Education Health Certificate, Assistant in Nursing, Enrolled Nurse Advanced Certificate or Registered Nurse Bachelor of Applied Science—Nursing.

However, while the pathways already exist and are used, issues raised with us concerned the maximising of credit and the lack of infrastructure to support individuals who wish to progress through the system.

Recommendation 12—Maximising education pathways

To promote career transitions and opportunities for development in the education and training of care assistants, health workers, enrolled nurses, registered nurses, midwives, nurse practitioners, nurse educators and nurse managers, education providers should seek ways to:

a) maximise the potential for Recognition of Prior Learning (RPL) and Recognition of Current Competency (RCC) in enrolment processes

b) in consultation with local Indigenous communities, improve articulation pathways for Aboriginal and Torres Strait Islander peoples.

Proposed responsibility: Education providers
6.3.2 Multiple entry points and learning options

Careers information on nursing should highlight the range of entry points and learning options available for students or those entering nursing as a second career. Opportunities need to be created for professional development linked to promotion, and for continuing education to lead to specialisation in a field. Pathways from trained care assistant to registered nurse already allow for multiple entry and exit points and these should be clearly delineated so that all intending nurses can see the possibilities available to them. One such example is found in Port Pirie.

Port Pirie Regional Health Service New Apprenticeship Scheme

In 1999 the Port Pirie Regional Health Service, in partnership with the local TAFE college, designed a training program where students undertake the 12-month Certificates II and III in Community Care as the first stage towards an enrolled nurse program. During this time they are employed on contract to work in the hospital's aged care facility for 15 hours per week.

At the completion of the contract, those wishing to continue their training to enrolled nurse status, are offered employment on the same contract basis. These students work in the acute areas of the hospital for a further 12 months or until they become enrolled nurses. They are then eligible to apply for any vacant enrolled nurse positions, including the graduate enrolled nurse program.

The New Apprenticeships scheme at Port Pirie Regional Health Service commenced in February 2000. The program has been very successful with all 10 participants gaining Certificate III qualifications. Four of them remained on staff and are going on to complete their enrolled nurse training. If they do complete, they will be eligible to enter the hospital’s scholarship scheme, attend a university as an external student, obtain a degree in nursing and become registered nurses. The scholarship secures the financial support of Port Pirie Regional Health Service for further study.

In 2002, school leavers were the target group for recruitment rather than unemployed persons with 10 young school leavers commencing in February.

6.3.3 VET-in-schools

One approach to introducing young people to the possibility of careers in nursing is through VET-in-schools programs. A number of State education departments have reported success with their VET-in-schools program, and the following case studies show how this arrangement can work. Some provide experience in settings where nurses work, others show planned pathways from school to nursing, many of which combine general studies, vocational studies and work. Three examples of programs for senior schools students are summarised below.
Launceston Presbyterian Nursing Home for the Aged

Students working in aged care at Launceston Presbyterian Nursing Home for the Aged carry out work tasks as part of a structured workplace learning program. The nursing home provides accommodation for 75 high care and low care residents. The nursing home became involved in student work placements after being approached by a VET teacher from Launceston College.

The nursing home has found benefits in bringing senior high school students into the home to develop skills under the guidance of experienced aged care professionals. The nursing home reports that recruitment costs are lowered because the home can draw on a pool of trained workers already familiar with the facility. The mentoring role staff take on with the students has developed their training and supervisory skills.

Since 2000, more than 60 students from Launceston College have participated in the program each year. Studying for their Certificate II or III in Community Services (Aged Care Work), they develop skills in occupational health and safety, first aid and manual handling before entering the workplace. They then complete the nursing induction course and spend one day a week at the home for approximately 26 weeks. During this time, students are teamed with a staff ‘buddy’, and are involved in diversional therapy activities such as bowls and reading. They also assist with more demanding tasks such as showering and personal care of residents.

More than 75 per cent of students have been offered jobs in the industry or have opted for further industry training (ECEF 2002).

Ceduna Hospital Nursing Traineeship Pilot

In the Ceduna Hospital Nursing Traineeship Pilot Project, school students from Years 11 and 12 have been encouraged to consider nursing as a career option. Students were asked to volunteer for the program in which they could undertake training to start them on a nursing pathway. The students went through a selection process involving voluntary work experience, a written application and an interview. Four students were selected to participate.

Utilising a school-based New Apprenticeship model, the program was facilitated by an approved local group training company and relied on close links being formed between the students and their parents, the school, group training company and health services.

The program ran over a two-year period. During the first year, students completed Certificates I and II from the Community Services Training Package. They undertook a mix of theoretical studies at TAFE and on-the-job work experience in residential aged care units. The group training company was able to utilise the Commonwealth employer incentives to pay the students for the time they were in the facility, thus making the students effectively an extra staff member at no extra cost to the unit. When the student was not undertaking clinical placement or TAFE they were still involved in their normal school studies leading to their South Australian Certificate of Education.

The second stage of the program was designed to follow as a pathway when the students finished school. The trainees would have continued to work at the local health unit as nurse assistants employed by the unit, rather than the Group Training Company. Again, Commonwealth employer incentives would be utilised to assist with the employment costs. The students would have been able to continue their studies to complete Certificates III and IV and on to become enrolled nurses if they chose.

Of the four students who initially undertook the program, three continued to tertiary studies in nursing. Despite the small numbers involved, the program demonstrates how rural communities can develop models to effectively engage young people at school and help them move through a pathway towards nursing.
Care and Health Industries Pathways for Schools—South Australia

The Care and Health Industries Pathways for Schools (CHIPS) is part of a model for the development of vocational education in schools to meet the requirements of the South Australian Certificate of Education. The CHIPS framework includes five streams from the Community Services Training Package, four at Certificate II and one at Certificate III. In addition, there is a pathway that opens into Leisure and Health studies through TAFE SA. The four pathways at Certificate II are Aged Care/Disability Care, Children’s Services, Youth Work/Community Work and Leisure and Health.

The framework is based on an accredited curriculum for Community Services and Health at Certificate II and consists of a specified number of common compulsory units of competency and specified numbers of elective units of competency. After consultation with industry, training and teacher representatives, the CHIPS units of competency have been identified as appropriate for delivery to secondary students.

CHIPS is designed as a two-stage program. The first stage, the compulsory units of competency, provides a general understanding of the care and health industries and some experience in the workplace doing real tasks, thus helping students decide if this is the pathway they wish to follow. The second stage offers students a more in-depth look at a particular area. It requires a higher level of involvement with clients and residents and a greater knowledge and skills in specific industry units of competency.

CHIPS defines a specific sequence of units of competency, and it is recommended that some of these be completed before students undertake work placement. As a generic model, CHIPS is designed to expose students to at least two different streams in Community Services and Health. Work placements in two different industry areas are also recommended, so students may broaden their horizons beyond their current understanding of Community Services and health.

Compulsory units of competency—must be undertaken before a student can go on a work placement and must have a Community Services and Health focus. Some compulsory units of competency may be taught as part of a generic VET program.

Elective units of competency—the compulsory units of competency are followed by electives from a specific area. It is expected that the students will study at least two of these areas with a combination of on- and off-the-job assessment.

Work placement—meaningful tasks should be undertaken to enable a real understanding of the nature of the specific industry, assessment of learning outcomes/competencies should be based on real tasks, and a minimum of 10 days is encouraged (for example, two places of five days in each workplace).

6.3.4 Enrolled nurse education

Price and colleagues (2001) outlined the different entry points and learning options for enrolled and registered nurses in their Nursing Career Pathways project and provided some ideas about career pathways and options. Figure 6.1 outlines some of the options and opportunities available for enrolled nurses. Entry into enrolled nurse education can be via various options, including mature age entry, and those with Certificate III/IV articulating to Certificate IV/ diploma level (depending upon the State or Territory). Further, Year 11 and 12 students can enrol directly into certificate or diploma level courses, or can build on VET-in-schools courses they completed previously.
People with a Certificate IV or a diploma in enrolled nursing have a number of career and professional development/ongoing learning options. They can choose to undertake further VET courses in nursing specialisations, additional certificates or change to a related technologist occupation. They can decide to undertake staff development courses, or more informal personal development courses. They also have the option of undertaking tertiary studies, either a Bachelor of Nursing, or perhaps a degree course in another related field of study, such as health management or administration.

Figure 6.1 Entry points and learning options for enrolled nurses

![Diagram](National Review of Nursing Education 2002)

6.3.5 Registered nurse education

Figure 6.2 outlines some of the possible entry points and learning options for registered nurses. As with enrolled nursing education, the options are numerous. Entry to a Bachelor of Nursing can be via direct entry with the required university entrance score, from Certificate IV/Diploma for enrolled nursing, mature age entry or entry via a related discipline as a graduate or student.

Upon completion of a bachelor degree, registered nurses have a variety of career options and opportunities available to them. Studies for various certificates can also be undertaken through other providers than universities, such as the NSW College of Nursing or hospitals. Specific postgraduate programs are offered through universities in nursing related specialisations or in other fields at graduate certificate, graduate diploma, masters and doctorate level, including opportunities for research.

Source: Figure 6, Price et al. 2001
6.3.6 Links to employment during education

During the course of this Review we were presented with numerous examples of nursing students (both enrolled and registered nursing) being employed in the nursing industry while they were undertaking their studies. McKenna and colleagues (2001) stated that 'TAFE institutes across States and Territories (excluding New South Wales) reported that between 25 and 75 percent of Enrolled Nurse students were employed in areas related to nursing' (2001 p. 23). Duffield and team (2002) found in their study that some institutions employ students as Assistants in Nursing. Public institutions are less likely to employ students than private institutions. The three sectors, private for profit, private non-profit and charitable utilise student as AINs at fairly similar levels (46 to 51 per cent) compared to the 24 per cent of public institutions.

We noted with interest comments by Southern Health in Victoria about a strategy that could help student nurses gain more experience in service facilities by working during their studies (that is, student fellowships) and that existing partnerships between universities and hospitals could be explored to offer employment to students under a fellowship scheme while they are studying.

The fellowship model currently in place at Southern Health and in collaboration with Deakin University allows for learning while working outside the curriculum ...

The student is responsible for looking for the part-time employment opportunity (supported by education and service). An advantage of student fellowships is that students develop a sense of belonging, learn the culture of an organisation and have more clinical experience. The main disadvantage is the students may be enculturated by an organisation and not have the opportunity to experience other philosophies of care. This could be overcome if universities, industry and Governments developed statewide models of student fellowship.

(Southern Health, response to Discussion Paper)
We heard mixed comments about students being employed in some capacity in work related to nursing during their studies. Our support for student employment is premised on the separation of employment from any educational requirements, including the clinical placement component of their studies. We do see some benefit of exploring this issue further for both the health, aged and community care sectors, and the students. We therefore consider that this is an area the NNCA should examine with a view to a national approach that would enable nursing students as employees to ‘practise’ at their level of competency.

Recommendation 13 — Student nurse employment
With a view to achieving national consistency, the NNCA should examine the financial benefits and experience that might accrue to student nurses (and the implications for the workplace) from their employment in the health workforce at their level of competence (but not as part of the requirements of their educational program).

Proposed responsibility: The NNCA

6.4 Transition
Transition between different roles will be an increasing feature of the workplace of the future. The high levels of specialisation develop they will also be rapidly overtaken by changes in knowledge and technology. Opportunities to progress to work requiring a higher levels of competency will be needed to ensure a workforce for the future. There will also be times of withdrawal from the workforce due to family or other commitments. Consequently, the need for organisations to include transition processes and support will increase. To support these transitions (whether the service is to acute patients, the elderly or the community), organisations will need to develop strategies to encompass transition processes as part of normal operations. To achieve this will require some investment in educational infrastructure and teaching expertise in clinical areas.

One important transition is that from education to the role of professional. The Organisation for Economic Co-operation and Development (OECD) report Knowledge Management in the Learning Society (2000) notes that there has been little concentration on the learning that occurs in the workplace, despite the lack of satisfaction of new professionals with this transition. It identifies the growth of mentoring of new professionals as an important development, not just for the new professional but also for the mentor and the organisation because of the capacity for this arrangement to promote innovation. The report argues that when theoretical knowledge and practical knowledge interact the conditions for innovation exist so ‘mentoring can be the midwife of innovation’ (OECD 2000, p. 55).

Hargreaves (2000) also explores the theme of becoming a professional, which he describes as ‘becoming a full member of a community of practice’. To achieve this, individuals need the appropriate knowledge and skills but also the relevant identity, both of which are acquired by participation. In becoming a professional he claims that:

Novices learn not merely to talk about the practice of their profession, but within it. Learning is not merely a condition for membership of the community of ... but it is itself an evolving form of membership (OECD 2000, p. 225).
Since nursing education moved from the hospitals to the universities, there has been much discussion about the readiness of the new graduate. The Reid Review (1994) has an extensive discussion of this issue and the same issues were raised again in the current review. The disparity between the expectations of the care services and those of education of new graduates does not appear to have been resolved. Indeed, the current difficult working environment may well have exacerbated it. However, the view that graduates perform confidently within six months of graduation has not changed (Duffield et al. 2001). Graduates of nursing degrees are prepared as entry-level practitioners of a profession that works in many different settings. As such, each new graduate will need time to adjust to a particular practice setting as well as time to develop as a confident member of the profession. When stronger partnerships between education and practice sites occur we hope that there will be better agreement on the expectations of new graduates.

The 1994 review had as part of its terms of reference the question of whether an internship should be included before registration. Like that Committee, we do not support an internship for the following reasons:

- an internship is not necessary to ensure the clinical competence of graduates
- not all nursing students can be assured of the offer of an internship within a reasonable period of graduation, and those students failing to complete an internship would then be unable to use their nursing qualifications.

6.4.1 Programs for new graduates

New graduate programs are offered to nursing graduates as part of the transition process from university to employment as a nurse. There are few graduate programs for enrolled nurses. Although in some States there is a big investment in these programs for new university graduates, the amount of funding provided varies and the accountability for the funding is not specific. Some non-government facilities also offer graduate programs, sometimes with State government support. The access to new graduate programs also varies. For example, the Tasmanian Government is committed to offering all new graduates a graduate program. We hold the view that all new graduates, enrolled or registered, should have access to a transition program.

Respondents to the Review also suggested that the quality of programs varies. Since the programs depend on the support available in the facility, in times of shortage it is difficult to provide appropriate support to the new graduate.

The interdependence of these factors is well presented in the following statement from Southern Health:

On completion of education and training nurses face a period of adjustment where they are required to bring together their theoretical and professional knowledge.

A concerted effort by universities, Government and health care agencies needs to be made to ensure that transition year programs adequately assist the new graduate for their new role. It is essential that new graduates have an appropriate level of clinical ability when joining the workforce both following undergraduate and postgraduate courses. Measures that could be undertaken to facilitate this process are:

- an active recruitment and retention program for experienced nurses. The aim of this suggested strategy is to ensure that there is an appropriate staffing profile to ensure graduates have adequate support during this transition period,
• a standardisation of Graduate Nurse programs nationally that acknowledges what graduates have been taught, their level of competency and realistically identifies the knowledge and skills they require to be effective members of the workforce.

(Response to the Discussion Paper)

In summarising the issues, Southern Health raises a matter that was also part of the discussion of the Reid Review (1994). While the 1994 review did not support standardised programs it did suggest a review of the ANCI competencies to ensure that they meet the expectations of employers of beginning practitioners as well as the registration boards’ expectations for registration (Reid 1994, p. 241). To a degree, this is the same issue we raise in Chapter 7 when we address the lack of consistency in the interpretation of the ANCI competencies between nurse registering boards and universities.

To encourage greater quality and consistency we propose that the ANCI develop minimum standards for transition programs to be endorsed by the NNCA. The principles that underpin these standards should include that the transition programs for new graduates should:

• build on entry level competencies to support the integration of theory and practice
• be competency based
• not replicate content covered through universities or VET nursing preparation programs
• be available in specialty fields as well as more general nursing fields
• offer new graduates a range of experiences.

Recommendation 14 — Standards for transition programs

To ensure consistency and quality in the development and delivery of transition programs:

a) a national framework should be developed for transition programs to provide guidelines and standards for institutions
b) State and Territory nursing registration boards should accredit transition programs
c) employing institutions should be responsible for meeting the standards.

Proposed responsibility: ANCI in consultation with the NNCA, State and Territory nursing registration boards and employing institutions

6.4.2 Continuing clinical development

In comments to the Discussion Paper there was a strong call for adequate funding and a range of other support options to be provided for continuing development for nurses. These included:

• professional development plans for individual employees
• career paths identified for all levels of nursing
• mentoring programs or structured preceptorship programs available to all staff
• establishment of clinical coordinators/preceptor positions to aid workplace transition and workplace development
• transition programs that allow new staff to be supernumerary for a designated period.
Other suggestions were about paid study leave, and the establishment (or maintenance, where they are already in place) of professional development/education units and clinical nurse educators.

We also recommend that all State and Territory governments commit to transition programs and that they build up the clinical support infrastructure to promote clinical development for all nurses. Further we encourage governments with their respective responsibilities to encourage transition support programs in aged care.

**Recommendation 15 — Continuing clinical development of nurses**

To promote the ongoing development of nurses’ clinical competencies in the workplace, Commonwealth, State and Territory national health funding arrangements should dedicate funds to the provision of:

- a) clinical development support in healthcare settings for nurses at all levels and the necessary infrastructure for education and training in the healthcare system
- b) transition to practice programs for new nurses, both enrolled and registered, and for nurses returning to the workplace
- c) support for these developments, including preceptorship and mentoring.

**Proposed responsibility:** Commonwealth, State and Territory health ministers

**Recommendation 16 — Continuing clinical development of nurses: aged care**

To promote ongoing development of nurses’ clinical competencies in their workplaces, Commonwealth, State and Territory aged care responsibilities and funding arrangements should:

- a) endorse and ensure continuing support for the standards and guidelines for residential aged care services in relation to the clinical education of nursing staff as outlined in the aged care accreditation standards
- b) endorse and encourage the provision of transition programs for new graduate nurses, both enrolled and registered nurses, in aged care organisations.

**Proposed responsibility:** Commonwealth Minister for Ageing

There are a number ways transition to practice could be supported. The Queensland University of Technology has an interesting idea for transition support programs:

An innovative strategy for the future development of transition support programs could be the instigation of a tendering process for the provision of a transition support service to complement organisational orientation within particular facilities or groups of facilities, eg. aged care. The successful tenderer, eg. university and health care service partners, would be responsible for delivering the educational and administrative elements of the program, would oversee its implementation and would be responsible for its evaluation. In fulfilling these functions program providers would work closely with health care service personnel to ensure the relevance, contemporary significance and operational efficiency of the program.

(Queensland University of Technology, response to the Discussion Paper)
Since transition support is an investment in an ongoing nursing workforce, governments need to prioritise this support in funding arrangements, particularly for new graduates. The loss of graduates, either at the point of entry to the workforce due to lack of available transition programs or in the first year after graduation due to inadequate support, is a matter of particular concern in times of short supply. It is also at these times that informal support for new graduates is likely to be less available, making it imperative that formal processes are well established.

**Recommendation 17 — Transition to workforce: funding**

The Commonwealth, States and Territories should establish a system to allocate dedicated funds to (public and private) health and community care institutions to assist registered nurses and enrolled nurses in making the transition into employment, including the transition into employment of those nurses who have completed a re-entry program.

- Allocations should attach to the individual employee or registrant (and should be made on their behalf) to institutions whose programs have been accredited for transition.
- Transition programs should be encouraged in areas such as mental health, aged care, community nursing, and rural health, as well as hospitals.

**Proposed responsibility:** Commonwealth, State and Territory health ministers

6.4.3 Re-entry

Nurses who have left the nursing workforce previously should be supported to assist their return to nursing. Re-entry courses should be easy to access, affordable, and should help nurses with lapsed registration return to the workforce. A number of State health departments fund refresher and re-entry courses, many into specific nursing areas where shortages are being experienced.

To reduce the need for extended re-entry programs a long-term strategy would be to encourage nurses who have taken extended leave to retain a current level of experience and to keep in touch with the workplace. Creative programs to ensure skills are updated when not working in a clinical area are needed for a number of different groups, including nurse academics, nurse policy makers and nurses on leave. We encourage the development of such programs.

6.5 Ongoing learning

Price and colleagues outline the scope of ongoing learning opportunities for nurses in their report.

Ongoing learning options include professional development courses, sessions conducted by professional nursing organisations or employers, personal ongoing learning contributions by each nurse, vocational education and tertiary educational options (2001, p. 32).
When considering the ongoing learning options for nurses we examined the opportunities offered or taken up by nurses to enhance their professional development, career progression, maintain their currency of knowledge and assist in defining their career pathway opportunities. Within this group of activities is the preparation and development to work in specialist nursing fields. This topic is discussed in Chapter 7 with the more formal models of education and training.

6.5.1 Continuing education

Ongoing professional development through continuing education is crucial to any nursing career pathway and to being a member of a profession. The Royal College of Nursing, Australia in the Position Statement Continuing Professional Development states:

Continuing professional development for nurses is essential to ensure that nursing practice is congruent with the health needs of contemporary society. Competence to practice is dependent upon updating knowledge and skills and the personal and professional growth of practitioners within a discipline. Professional development is a career-long process. It is stimulated by experiential and other learning, which may occur in a variety of ways and includes but is not limited to, formal award educational programs (RCNA 1998).

Nurses should rightly expect to be offered opportunities for continuing professional development in their workplace. This development is often a key factor in retaining them in the nursing workforce and helping them develop their career options. Many submissions raised the cost-cutting and rationalisation of funding in the healthcare system that have impacted on support for continuing professional development for nurses.

In its submission, the National Nursing Organisations argued that there is a lack of commitment by employer groups to ensure that nursing staff maintain best practice in clinical practice, nurse education and nursing research by providing conditions that allow staff to engage in continuing education. It stated that:

budgetary constraints and staff shortages within the healthcare sector have seen the diminution of resources available for employment-related nurse education, including nurse educator positions, classroom and teaching resources and study leave (NNOs, Submission No. 108 to the National Review of Nursing Education).

In Chapter 2 we argued that nurses should demonstrate ongoing education to maintain competence and re-registration. In order to achieve this all nurses will need access to professional development materials and opportunities.
Recommendation 18—Lifelong learning and nursing competency

Given the challenging tasks undertaken by nurses and the rapid changes that can occur in technology, knowledge and skills, all nurses should be expected to undertake continuing education activities to maintain and enhance their professional competence and this should be taken into account in retaining registration or enrolment. To ensure this is possible:

a) employers should develop strategies in their local areas to provide the opportunity for registered and enrolled nurses to keep their nursing competencies current so that they can retain registration

b) employers could also provide opportunities to those not presently in employment to access appropriate fee-paying courses to maintain competency

c) nursing organisations should develop educational material to support the maintenance of nurses’ competencies in relevant areas.

Proposed responsibility: Employers, nursing organisations and individual nurses
7 Education and training

This chapter addresses the issues that impact on the quality of education and training for nurses and trained care assistants in terms of their competencies (skills, knowledge and attitudes) and the flexibility of models to respond to evolving needs in the sectors in which nurses work. Issues of supply are dealt with in Chapter 8, though there is a relationship between the recommendations in this chapter and the quality of care. There is no detailed material on the trained care assistant since the national training packages are relatively new. The focus is therefore on the supply of an appropriately skilled workforce of trained care assistants. The recommendations about trained care assistants are in Chapters 5 and 8.

7.1 Quality issues

There is much to celebrate in the innovation, flexibility and quality of the educational preparation of Australian nurses. The considerable progress in the development of a system of education and training allows people to progress through different levels from carer to the highest levels of nursing expertise. The education and training systems offer different modes of course delivery, including part-time enrolment and distance learning. Traineeships are available for the preparation of enrolled nurses and for trained care assistants. Even in the vexed area of national consistency of standards and preparation, key national agreements are in place. Australia is already meeting many of the fundamental principles of initial nursing education programs for nursing promulgated by the World Health Organization (WHO) (see Attachment 2.1). Compared to many other countries, Australia’s nursing students are offered a greater degree of choice and flexibility, in both programs and locations.

There have also been collaborative developments between healthcare organisations and universities in areas such as cooperative research, in the development and sharing of expertise and in education. Some of these initiatives include joint appointments of professors and tutors, advice on the curriculum, and clinical education agreements for both undergraduate and postgraduate courses. To add to these innovations there is a culture in nursing that values education and training. Collaborative arrangements exist between Australian and overseas universities. This is in part due to the expertise of Australian nursing academics and researchers.

While still in its early days in the university system, Australian nursing education is ahead of many countries moving in that direction. There are also partnerships between universities and TAFE institutions, and agreements to formal credit arrangements for linked qualifications.

Despite these successes there are tensions and pressures that put the future quality of graduates at risk and areas that need further development. Stress is not uncommon in systems that face the level of rapid change that health care and education experience. While the existing weaknesses and barriers to development are the focus of the remainder of this chapter, the achievements presented above should not be forgotten.

7.1.1 National standards

The growing interest in quality and assurance of quality are evident in the theme of national consistency for the preparation of registered and enrolled nurses. In the profession there is acceptance and endorsement of the Australian Nursing Council Incorporated
(ANCI) competencies, although there is little support for a national curriculum. However, there is some frustration with the latitude available in the interpretation of the ANCI competencies. The course accreditation processes of individual States and Territories add to the potential for breadth of interpretation of the standards. The following comment from the School of Nursing, Monash University, summarises the position of many groups.

Variety and diversity should be encouraged. ANCI [competencies] should be clear and more comprehensible. ANCI provide outcomes and not a framework for educational curricula. The development of ‘minimum standards’ or more clearly defined outcomes would assist in developing a greater level of confidence in the capabilities of new graduates. We do not support the idea of a prescribed or common curriculum across Australia. Local context is always important.

(School of Nursing, Monash University, response to Discussion Paper).

During the visits to universities, we talked to students who at times held very different views about the educational program from those of the academics. Hospital staff also made comments about the quality of the preparation of the students from different universities. While research such as that by Duffield and team (2001) and Clare and colleagues (2002) shows there is no concern with the general standard of preparation of registered nurses, we believe that universities need to evaluate all aspects of their program regularly. Evaluations should include feedback from the hospitals where students gain clinical placements and employment on graduation, and from students and past students. Where universities have small remote campuses or large components of distance learning in their nursing programs, there are risks to student outcomes if these programs and their delivery are not adequately monitored for quality.

7.1.2 Course accreditation

We recognise that there are systems of quality control in both universities and State and Territory nursing boards to monitor nursing curricula and that there are supporting materials for the assessment of the ANCI competencies. However, there is no system to support monitoring for a national standard. We endorse the need for a more nationally consistent approach to the accreditation of courses. This can be achieved in the absence of national accreditation of courses by the development and acceptance of national guidelines that define minimum national standards for course accreditation and assist in more coherent curriculum development. These standards should apply to both enrolled nurse and registered nurse programs. The ANCI, in association with the proposed National Nursing Council of Australia (NNCA), is in an excellent position to develop guidelines to define minimum standards for the accreditation of courses for the preparation of registered and enrolled nurses, and for the support of the transition of new graduates. While nursing does not yet appear ready for a national system of course accreditation or registration, debate on this issue is likely to continue and may be encouraged by the Australian Council for Safety and Quality in Health Care.

The system of quality assurance for the vocational education and training (VET) system has recently changed. This system is particularly important for VET because of the wide range of training providers. In some States there is a strong market of private training providers but in others most training is done by TAFE. The new national framework, the Australian Quality Training Framework (AQTF), provides standards for the accreditation of courses and registering training organisations in each State and Territory.
The AQTF is a set of nationally agreed standards to ensure the quality of VET services throughout Australia. It replaces the Australian Recognition Framework (ARF). The AQTF ensures that all registered training organisations and the qualifications they issue are recognised throughout Australia.

States and Territories are responsible for the quality of VET. They apply the Australian Quality Training Framework (AQTF) framework when:

- registering organisations to deliver training, assess competency and issue qualifications which fall under the Australian Qualifications Framework (AQF)
- auditing registered training organisations (RTOs) to ensure they meet and continue to meet the requirements established by the framework
- applying mutual recognition
- accrediting courses.

The AQTF includes two sets of standards: Standards for Registered Training Organisations and Standards for State and Territory Registering/Course Accrediting Bodies. The new framework makes auditing of training and assessment activities clearer, more transparent and more consistent. Implementation of the AQTF began in June 2001 and will be completed by 1 July 2002.

7.1.3 Vocational education and training (VET) and quality control

During our visits and the consultations, we had the opportunity to talk to enrolled nurses undergoing training and those involved in training them. We were concerned with the reports we received about some enrolled nurse training, in particular some traineeship options. It is evident that there are some excellent training organisations involved in enrolled nurse preparation in both the public and private sector, but there are clearly those that need greater monitoring. The same would no doubt apply to the training of care assistants. Poor training programs present a risk to safety for the public, but also undermine the continuing credit arrangements in universities that allow career progression. Universities must ensure the quality of their graduates. If the provision of credit to enrolled nurses who are then found to be inadequately trained puts the quality of university graduates at risk, the system of articulation is likely to be undermined.

For these reasons, the involvement of the State and Territory nursing registration boards in course accreditation for enrolled nurses must be maintained. The links between the different levels of nurse preparation need to be further developed. Better linkages will depend on greater national consistency in the interpretation of the ANCI competencies by the registration nursing boards. The newly agreed revisions of the ANCI competencies for enrolled nurses should assist with the development of the links to registered nurse preparation. The requirement for the nurse registration boards to retain their involvement in course accreditation is another protection in the system. Issues of national consistency in nurse preparation were canvassed even more strongly for enrolled nurses than registered nurses. This matter has already been raised in Chapter 5 and will be discussed in more detail again later in this chapter.
Recommendation 19 — Models of preparation
To assure quality programs, undergraduate and enrolled nurse courses should continue to be accredited by State and Territory registration boards in accordance with national principles developed by the ANCI and endorsed by the NNCA. These principles should ensure that:

a) graduates from these courses meet the ANCI competency standards
b) quality assurance processes for course accreditation and the assessment of students are met
c) there is ongoing evaluation of the curricula and teaching practice in the light of changes in nursing practice, research on learning, and the broader developments in professional and para-professional preparation.

Proposed responsibility: ANCI in consultation with the NNCA

7.1.4 Curriculum and assessment
There will be ongoing developments in the areas of curriculum and assessment in nursing education. Some of these will be due to new demands in health, aged and community care; others to developing priorities or new approaches including multi-professional service delivery and integrated models to manage care.

Areas in need of development
As discussed in the material on evolving models of care, new strategic frameworks that rely on multi-professional approaches have implications for nursing curricula. These new directions are often targeted at the university preparation of nurses, but the implications for enrolled nurses should not be overlooked. Enrolled nurses work in the same work settings as registered nurses and with the same client/patient groups.

The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in early 2000 by Australian Health Ministers to lead national efforts to improve the safety and quality of health care provision in Australia. It reports annually to all health ministers and is supported by State and Territory governments. It considers education a key lever to promote improvements in the safety and quality of patient care. For this reason it is supporting a number of education and training initiatives designed to achieve the following:

• raise awareness of patient safety and systems improvement
• develop knowledge and skills in specific priority areas such as risk management;
• encourage the adoption and spread of safety and quality tools and approaches.

One such project is preparing a framework of knowledge, skills and attitudes about safety and quality in health care to be included in undergraduate medical and nursing education. Future work may focus on developing innovative, multi-disciplinary educational approaches to integrate the framework and promote uptake in medicine and nursing curricula (ACSQHC 2002).
Areas of challenge

Clare and colleagues (2002, p. 3) document a few areas they identify as matters of concern in their evaluation of nursing curricula in universities across Australia. These are listed below for consideration:

... the overall high number of assessments; failure of eight curricula to include reference to coverage of indigenous health issues; the failure of eleven to include rural and remote health issues; the failure of five curricula to include IT and technology teaching or discussion; the general failure to include discussion of the changing nature of hospitalisation; and the lack of evidence of feedback from or involvement of health consumers in nurse education.

Indigenous health

Ensuring that Indigenous health issues are part of the core elements of the curriculum is an objective of a working party established by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) with the Australian Council of Deans of Nursing, discussed earlier in Chapter 6. This issue is being addressed through the work of that working party.

Rural and remote

As universities and TAFEs are located across Australia in both metropolitan and rural areas, there may well be an argument that one of the features that should distinguish nursing programs is the different theoretical context used by different education providers. Building comprehensive curriculum that examines issues through the particular challenges of the local area would mean that rural and metropolitan providers would use different theoretical contexts in preparing nurses. Indeed, during the consultations nurse academics argued that responding to local circumstances is important in the design of curriculum.

Rural universities and rural campuses are in an excellent position to develop programs that place a priority on the understanding of rural health issues and use the rural nursing context. Metropolitan universities may offer students rural placement. These may be part of electives in rural health and incorporate rural clinical placements (for example, Flinders University and Victoria University) but this is not always the case. Mahnken (2002) criticises the encouragement of clinical placements in rural areas for students from metropolitan universities when these placements are not contextualised within the educational program to demonstrate a rural health perspective.

Mental health

Another challenge for the preparation of nurses under the comprehensive model has been to provide enough practical experience and sufficient time in the program to treat mental health and illness adequately (Clinton et al. 2001). Despite considerable challenges, we support the existing model because all nurses in whatever context of care will need to be grounded in mental health understandings and the management of patients who have mental health problems. For those nurses who wish to specialise in mental health nursing, the undergraduate preparation must provide an adequate foundation to enable specialisation, which could be achieved by one of two models. The first is by adding an additional major study onto an extended undergraduate course; the alternative is through postgraduate education. The development of National Practice Standards for the Mental Health Workforce will inform future developments in this area (see Chapter 4).
Aged care
Aged care is in a similar position to that of mental health in that all settings in which nurses work will deal with growing numbers of elderly people. Pearson and colleagues (2001) identify the limited focus given to aged care in pre-service education programs. Most of the energy in these programs is directed to primary health care and the delivery of acute care services. A broader focus on aged care in undergraduate nursing programs is needed to respond to the external pressures of an ageing population. Enrolled nurse programs have had high coverage of aged care in the past and this will need to be maintained along with the broadening of that curriculum.

Other issues
These various challenges reflect the continuous demand for nursing curricula to cover more material and/or greater depth of theory in particular fields. Other pressures arise from public health issues that bring with them expectations that the nurse will lead in educating the community about public health risk and also take a key role in promoting positive community attitudes. Examples of these areas are AIDS and hepatitis C. Nursing competencies will need to be regularly reviewed to ensure they reflect the changes in care and social attitudes. Curriculum will need careful management and decisions about the length of programs will form part of that management.

Assessment of students
One of the more challenging issues for a practice discipline is that of student assessment. Graduates reported a low level of satisfaction with ‘assessment’ in nursing courses in university. The average ‘broad satisfaction’ score for ‘appropriate assessment’ in the Course Experience Questionnaire was between 33 and 39 in the years 1996–2000. This rating is low when compared with that of the general university student population who had a broad satisfaction rating between 84–85 across those years. While this single element of student experience is rated poorly, this is not true for other areas of experience as the overall broad satisfaction scores were between 83–91 for nursing graduates across the same period (DEST 2002b).

Although it should be remembered that while the level of satisfaction with the assessment process among nursing graduates is low, the assessment of competence to practise in nursing is a complex area (Redfern et al. 2002). The close links between competency assessment and students’ experience of practice mean that changes in hospitals and other service sites and the consequent evolving nature of scope of practice ultimately impact on student assessment. Consequently, assessment will be an area of the learning process that requires constant renewal and evaluation. New professional approaches to decision making will also lead to the need for student nurses to develop skills in self-assessment. Improving student assessment processes will be an integral part of the development of the discipline of nursing.

7.1.5 Nursing in a culturally diverse society
A further issue for the comprehensive preparation of nurses both enrolled and registered is how to develop attitudes and understandings that enable nurses to practise safely within a culturally diverse community. To complicate this further, until recently Australians have given little attention to understanding our Indigenous population. While these issues are a challenge for the whole Australian population, nurses at the front-line of the health, aged and community care sectors are in particular need of appropriate cultural understanding and cultural safety.
The project conducted by Eisenbruch, Rotem, Waters, Snodgrass, and Creegan (2001) for the Review examined the assumptions and concepts that formed the foundation of the multicultural context of nurse education within Australia and mapped the ways in which nursing education addressed (or failed to address) multicultural health. The researchers summarised their findings in the following way for the research forum.

Although only a snapshot of the current situation in universities, there was a wide range of assumptions and concepts about the multicultural aspects of nurse education in Australia. The spectrum of responses ranged from a one-dimensional view that emphasised language and ethnicity to one that attempted to interweave culture and diversity into all units of nursing study. The stages of evolution apparent within the multicultural context of nursing education raise a number of critical issues:

- The extent to which individual or institutional exposure to diversity determines the presentation of culture within the curriculum and practice.
- The need for consensus and/or direction from peak professional nursing organisations about what aspects of multicultural health are needed for ‘cultural competency’.
- The need for a consistent framework for the multicultural context of nurse education.
- The importance of reflection and lifelong learning in increasing awareness of the social, political and economic contexts of culture and health, and developing culturally competent care.
- The need for systematic investigation into the cultural needs of students, staff, patients or clients and minimal effort to engage with other disciplines or communities in this work.

The researchers found examples of leadership in nursing education in this area were apparent, but the degree of uncertainty expressed about the multicultural context of nurse education, coupled with the high level of interest in the project, suggest a need for further work on this issue. The leadership of the ANCI in this regard will be invaluable in progressing this area for both enrolled and registered nurses.

New Zealand has taken a lead on ‘cultural safety’, an issue debated at some length in their recent review (KPMG 2001). Cultural safety relates to the promotion and protection of a person’s identity, rather than merely gaining an appreciation of the ritual, customs and practices of other groups. If nurses are to be effective in their practice they will need to understand the impact of social conditioning on the efficacy of healthcare provision. This understanding will be critical to promoting self-determination, which is a key aspect of cultural safety and one that will help create a health system that is responsive to the needs of a culturally diverse population. Particular attention needs to be applied in developing understandings about Australia’s Indigenous people.

We have identified that the NNCA should promote and facilitate consistency in education and training. This role will require ongoing monitoring of competencies for their relevance. In this regard, we would particularly seek consideration of the issues of cultural safety within the competency standards of the ANCI, though we note its expression may be different from New Zealand since not only our Indigenous people but also Australia’s diverse cultural mix challenge the community to demonstrate better understanding.

7.1.6 Currency of practice and education

As the ways new professionals are educated and trained begins to reflect the evolving understandings of how people learn, education and training providers will need to develop systems that provide incentives and acknowledgment of the importance of clinical currency in the academics and nurse teachers responsible for the education of new professionals. The
quality of the education received depends not only on the educational skills of teachers and
their theoretical understandings, but also the relevancy of the application of these
understandings in the practice environment. Since health care is a rapidly changing
environment, which uses technologies the education system can never emulate, being
current in clinical practice will require regular time working in the service environment.
Medicine has been able to achieve this more readily than nursing because the combination
of research, teaching and practice is supported by the way doctors are linked to particular
service facilities. For nursing—a more recent entrant to the university environment and a
discipline area that produces larger numbers of graduates than medicine with considerably
less funding—this will be a challenge.

A number of responses to the Review Discussion Paper urged universities to examine how
they respond to this as an issue of quality in their education programs. Suggestions about
how universities might assist with the development of a culture and expectation of practice
include the following:

Faculty practice should be built into academics’ workloads. Clinical consultancies
should be encouraged. Universities should allow clinicians to undertake additional
paid work, say up to 8 hours per week. Clinical currency could be included in
promotion criteria for academics. (Ron Kerr, response to the Discussion Paper)

Recommendation 20—Nurse academics and teachers
To ensure that students are exposed to current clinical practices, faculty practice
should be:

a) built into the workload of those nurses who teach nursing students in
universities and the VET sector

b) incorporated into annual performance appraisals.

Proposed responsibility: Education providers

7.1.7 Credentialing advanced practice nursing for specialist nurses

The issues of credentialing and course accreditation are often linked in discussions of
quality and safety. Credentialing is a recognised form of regulation, often self-regulation,
that usually requires the demonstration of competence for the purpose of public
accountability for the services provided. For entrants to nursing and midwifery this occurs
through the registration process, which requires the nurse or midwife to meet certain
qualifications and to demonstrate competency against the relevant AN1 competencies.
The courses undertaken to gain those qualifications must also be accredited. Further, some
nurse registration boards register or endorse to practise mental health nurses. Nurse
registration boards have also taken on this process for the nurse practitioner. The Australian
Nursing Federation (ANF) has also developed competency standards for advanced practice
nurses which are used in course design, though this is voluntary. Some moves have already
occurred in relation to the self-regulation process in several professional bodies, with a
number of nursing colleges offering credentialing to members.

The comments received on whether further credentialing of nurses in areas of specialisation
or advance practice would be helpful reflected a common theme of concern about the
inconsistency of standards for the different levels of education. However, respondents had mixed views about the benefit of credentialing. A number of responses called for the development of a nationally consistent framework and guidelines for the credentialing of advanced practice nursing and the accreditation of related education programs. Others felt that there was a lack of evidence that credentialing of nurses leads to better patient outcomes, stating that nurses are already strictly regulated in Australia through the requirements of the different nurses’ regulation boards. Accreditation of courses rather than the recognition of a level of qualification would be a very costly exercise and could lead to lack of flexibility to respond to new and developing areas.

The School of Nursing and Midwifery at Curtin University argued that there was a lack of evidence about the ‘benefits’ of credentialing. Table 7.1 was incorporated in their response to the Discussion Paper, and summarises a discussion around credentialing in Murphy (2001). The table outlines a series of statements supporting credentialing cited in the literature together with the School’s responses to each of these statements.

<table>
<thead>
<tr>
<th>General statements supporting credentialing</th>
<th>Responses to each statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides accountability to the public</td>
<td>Nurses are already accountable to the public through nurses’ registration boards’ councils established via each state and territory. Nurses/Nursing Acts. Nurses are bound by codes of ethics and professional conduct. The public has common law to turn to and nursing practice is strongly influenced by the concept of duty of care, which is taken very seriously by Australian nurses.</td>
</tr>
<tr>
<td>Credentialing provides for national standards</td>
<td>National standards exist through beginning and advanced competencies. The competency standards for the advanced nurse provide a generic base on which each specialty in nursing may build and may be customised to suit all nursing specialties. Some National Nursing Organisations have already customised these standards for their own nursing specialty.</td>
</tr>
<tr>
<td>Allows a sense of professional achievement</td>
<td>A sense of professional achievement can be found through professional experience and postgraduate qualifications.</td>
</tr>
<tr>
<td>Credentialing designates excellence</td>
<td>There is no evidence to support the assertion that credentialing promotes excellence. There is no evidence that patients suffer or are disadvantaged as a result of nurses not being credentialed.</td>
</tr>
<tr>
<td>Credentialed nurses provide enhanced benefits for the public</td>
<td>Movement between jobs in Australia is facilitated by mutual recognition agreements and recognition of qualifications and experience across Australia.</td>
</tr>
<tr>
<td>Facilitates mobility from one job to another</td>
<td>A wide range of National Nursing Organisations representing specialties defines each community of experts.</td>
</tr>
</tbody>
</table>

Source: School of Nursing and Midwifery, Curtin University, response to Discussion Paper.

The Royal College of Nursing, Australia’s Credentialling and Accreditation Feasibility Project undertook an examination of the issue of credentialing and reported in July 2001 (RCNA 2001). The aim of the project was to examine the feasibility of implementing a national approach to the credentialing of advanced practice nurses and the accreditation of related education programs. The project was not concerned with the merit or otherwise of credentialing of advanced practice nurses, but with the development of a nationally consistent approach for Australia.
The project’s report recommended the development of a nationally consistent framework for credentialing and accreditation, and that a consultative research and development project be established to further explore and test the options identified. It also noted the direction being taken by the Australian Council for Safety and Quality in Health Care in this statement:

It is evident that under the new incentives put forward by the Australian Council for Safety and Quality in Health Care (ACSQHC), all health professional bodies will be encouraged to develop accreditation, credentialling and recertification programs (ACSQHC 2000, p. 6 cited in RCNA 2001)

Work is currently in progress to develop a national standard in health care for credentialing and clinical privileging processes across Australia. This work may overtake any recommendation that we might consider. We support the current work in this area and assume that future developments in relation to nursing will be pursued in consultation with the NNCA.

7.2 Multiple entry points

In Chapter 6 we discussed the arrangements that provide a range of different pathways into nursing. These arrangements will only be maintained if graduates meet minimum standards regardless of the level of qualification. Further, they rely on the resonance between what is learnt in gaining the qualification and what is required for the occupation.

There is already evidence that consumers of education and training understand the multiple entry points into nursing and the qualifications that enable nurses to practise. This is evident in the high demand for enrolled nurse courses, which are often undertaken with a view to reducing the length of a nursing degree while at the same time working in nursing. These arrangements can be enhanced through clever curriculum design when appropriate. Bridging courses for enrolled nurses who wish to upgrade to registered nurses, such as the one at the Illawarra College of TAFE, which was designed with Wollongong University, can help nurses make this transfer.

The principle of articulation underpins the construction of the VET training packages, which are designed around competencies. The modules in a package are used in a number of different qualifications. Using competencies helps students identify the credit they should be entitled to when beginning training in modules from a new training package. Although it may be more difficult to meet the broader knowledge and specific discipline requirements at the higher levels of learning, all new course design should consider how to maximise student transfer between different levels of related courses efficiently.

This principle should also be a consideration for courses at the same level in related areas. For example, the new midwifery direct entry course should be mapped against nursing to provide clear linkages between its development and the identification of the credit it offers to those wishing to undertake a nursing course on completion of midwifery studies. This credit would allow nurses to gain a Bachelor of Midwifery as well as a Bachelor of Nursing, and the reverse for midwives who do not already have a Bachelor of Nursing. Similarly, those who have other qualifications that have an overlap with nursing competencies should have access to credit. Where appropriate this recognition should be considered for all health professionals in the design of university curriculum. The work of the Quality Assurance Agency for Higher Education in the United Kingdom on benchmarking standards for the different health professionals provides an interesting basis to explore this further. While we have heard differing views about the articulation of courses for
Aboriginal Health Workers, we believe that the principle of articulation should be a consideration when university degrees for Aboriginal Health Workers are developed to enable transition between careers.

Clearly, there are occupational and discipline areas where there will be little specific content or occupational competency overlap with courses like nursing. Many people enter university in their mid-adult years so they have a range of experiences through which they have developed other more generic competencies. While universities are already taking this into account in entry criteria, providing appropriate recognition of prior learning will be an area for continuing development as the need to simplify career transitions increases with the rapid changes in the workforce.

7.3 Initial education and training—enrolled nurses

There is growing recognition of the importance of enrolled nurses (the associate of the registered nurse) for new patterns of work organisation in all sectors involved in care work. The role of the enrolled nurse has been restricted by a number of factors, some of which are discussed in Chapter 5 in relation to regulation and legislation. Of all the groups involved in nursing work, enrolled nurses are the group for which the issue of consistency in education and training was most often raised in consultations. Further, there is frustration with the limitations imposed on their future growth by the current differences in their preparation in the different jurisdictions.

The different State and Territory approaches to enrolled nurses’ scope of practice have resulted in different levels of qualification as the minimum level for entry to practice. In Queensland, enrolled nurses must have a diploma. In other States and Territories Certificate IV is required but the length of study to obtain the certificate varies (see Chapter 2 for more information). If these conditions prevail, the potential of this group of nurses is unlikely to be advanced and future models of work organisation will be limited.

7.3.1 Enrolled nurse—barriers to practice

In Chapter 5 we addressed the need to remove the barriers to an appropriate scope of practice for enrolled nurses caused by some legislation and regulation. While removal of these barriers is essential, this will not on its own promote the greater consistency required to develop common career paths and recognition. To develop the appropriate level of qualification across Australia, the potential for enrolled nurses in new models of care needs to be considered. For this reason agreement on the entry level to practice needs to be based on a scope of practice that takes into account new thinking about delegation and the administration of medication and at the same time builds the fundamentals on which enrolled nurse specialisation can be developed.

Further, if the competencies of the enrolled nurse are not identified within the national training packages, their competencies are likely to be used by new roles that take up various aspects of the work of enrolled nurses. As part of the VET system, enrolled nurse preparation must take its place within the national training packages. Since the revised ANCI competencies are now available, it is time for that development to occur. We recognise that there are some challenges to the progression of this agenda due to the nature of the professional relationship between the two levels of nursing, which must be retained. However, incorporation of enrolled nursing in a national training package would enable the development of much greater national consistency and ensure that enrolled nurses retain and further develop their role in the health, aged and community care sectors.
Recommendation 21—Enrolled nurse competencies

To provide links to other training and to develop national consistency for the education and training of enrolled nurses:

a) the ANCI and Community Services and Health Training Australia should meet as a matter of urgency to ensure the ANCI competencies for enrolled nurses are incorporated in existing or new Australian National Training Authority sponsored training packages

b) in establishing the appropriate level of qualification, account should be taken of the training requirements for evolving models of care and changes in supervisory practice, including those related to medication administration and new enrolled nurse specialisations.

Proposed responsibility: Implementation taskforce

7.4 Initial education—registered nurses

To fill their role in the health, community and aged care sectors, nurses need to draw on a broad base of competencies. These competencies bring together scientific and social understandings, the capacity to work in and across teams of professionals with different specialist knowledge and the capacity and attitude to be responsive to change. In achieving this particular synergy, nursing captures in a unique way the care of the whole person.

7.4.1 Undergraduate education

Nursing is also in a singular position to take a key role as ‘knowledge broker’ (Stilwell 2002) in the many contexts of care. The broker role requires high levels of communication skills, broad scientific knowledge, understanding and trust. In addition the broker needs to be able to search, and retrieve information and then assess and critique that information. These skills will all need to be part of the development of the nurse for the future.

Consumers who have easy access to vast amounts of information will be in a strong position to negotiate service delivery, though not always on the basis of understanding the implications of the information available. Since those who do not have access to this information may be disadvantaged, the role of the knowledge broker may be to advocate for such people.

To achieve these roles, nursing education needs to be at a similar level to that of other professionals, and to meet the minimum standards of a bachelor degree. In most cases this is equivalent to a six semester program (three years full-time), though more extended programs already exist. We take the position that decisions about the duration of the degree should be based on the requirement that they meet the agreed standards set by the profession through the ANCI and the industry. In making the decisions on course length, universities should also have regard to the demands of industry for new staff, the cost to the student, and continuing developments in care systems which continue to increase the demands on curriculum. At the same time universities should monitor successful programs that continue to meet these standards within a three-year program as there may be other arrangements, such as work experience, that consolidate nursing competencies without the extension of the course length.
Recommendation 22—Minimum level of qualification for registered nurses

To ensure that registered nurses are appropriately prepared for their professional roles, the minimum level of qualification for entry to practice as a registered nurse should remain a university-based bachelor degree, with a minimum length equivalent to six full-time semesters.

Proposed responsibility: Commonwealth Department of Education, Science and Training, and State and Territory nursing registration boards

7.4.2 Comprehensive education

Australia has adopted a comprehensive undergraduate nurse education program, which enables nurses to work in the different contexts of nursing care. While there are tensions in trying to provide a comprehensive preparation for nurses, we believe the complexity of nursing today requires all nurses to understand mental health and mental illness, the ageing process and its associated disease burden, as well as the more general nursing competencies. Consequently we support the continuation of the current approach to the preparation of registered nurses, believing it promotes the best option for the flexible use of nurses in the health community and aged care systems.

7.4.3 Nursing particular groups of people

Building on the comprehensive program, nurses require additional education and training to work with specialty client groups such as those with mental illness and requiring aged care as well as specialisations such as intensive care. Recently, universities have been developing dual degrees. In nursing these models include a four-year program which offers students the opportunity to include an area of specialisation. For areas such as midwifery, aged care and mental health, these may present an opportunity to focus interest early in a career. This option might also be further developed for paediatric, Indigenous and rural nursing, all of which require special skills and knowledge due to the client group. These developments should be monitored and evaluated as part of the ongoing development of nursing education. At the same time, it is questionable whether these degrees should be called ‘double degrees’, since to do so tends to devalue the concept of a ‘degree’ when the same amount of additional study attached as postgraduate study will normally be recognised as a diploma. In addition these are not separate disciplines but extensions of the fundamental discipline of nursing. Perhaps they could be further developed within the concept of a double major.

7.4.4 Funding undergraduate nursing education

While universities themselves are autonomous bodies created by separate Acts of (usually) State and Territory governments, the Commonwealth has the primary responsibility for funding and policy in the higher education sector. It provides block grants to universities to meet a given target in terms of university load (places). Universities can distribute the funded load in response to demand or other priorities. While the trend is to a market-driven response model, the Commonwealth Government encourages universities to respond to the needs of the nursing labour market as well as student demand.

Not all of the funding for nurse education comes from the Commonwealth Government. Since 1989, students have made a contribution to the cost of higher education through the Higher Education Contribution Scheme (HECS). This scheme applies to undergraduate
nursing courses and to some postgraduate courses. The HECS payments go to government revenue, not directly to the universities. Universities can charge fees for undergraduate nursing courses to both domestic and overseas students within certain guidelines, but the vast majority of undergraduate nursing students pay HECS (see the discussion in Chapter 2).

The Government changed HECS in 1997 by introducing three contribution levels 'based on the actual cost of the course undertaken, the likely benefits to the individual and student demand' (DEETYA 1996, p. 10). Nursing was placed in Band 1, the lowest contribution band. Under the current scheme the contributions apply on a 'unit of enrolment' basis, so the student's contribution depends on the discipline from which the specific units of study are taken and on the unit's weighting in terms of equivalent full-time student units (EFTSU). Universities classify the units using the Department of Education, Science and Training (DEST) guidelines.

For nursing students, the effect of this change to HECS is demonstrated in Table 7.2 below, which shows the distribution of EFTSU for undergraduate nursing courses between 1997 and 2000. The increase in total units across the period is due to the decision to continue the previous contribution arrangements for those students who had begun their nursing program prior to 1997. By the year 2000, 17.5 per cent of the EFTSU in undergraduate nursing was in a higher contribution band than the band identified for nursing units. The consequence for students is that some are paying a higher contribution for a nursing course than others because of the classification of the units in their course. While some of this effect may be due to choice of electives, this is not the only cause.

Table 7.2 Undergraduate actual student load (EFTSU) on a differential HECS liable basis for nursing students by HECS Band, 1997–2000

<table>
<thead>
<tr>
<th>Year</th>
<th>HECS Band 1</th>
<th>HECS Band 2</th>
<th>HECS Band 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>4 623</td>
<td>1 242</td>
<td>21</td>
<td>5 885</td>
</tr>
<tr>
<td>1998</td>
<td>8 646</td>
<td>2 251</td>
<td>47</td>
<td>10 943</td>
</tr>
<tr>
<td>1999</td>
<td>12 618</td>
<td>2 834</td>
<td>63</td>
<td>15 515</td>
</tr>
<tr>
<td>2000</td>
<td>14 128</td>
<td>2 976</td>
<td>33</td>
<td>17 137</td>
</tr>
</tbody>
</table>

Note: This data does not include non-differential HECS liable units resulting from studies commenced before 1997. Students who commenced their course of study prior to 1 January 1997 continue to contribute under the single HECS contribution Band in place at the time of their enrolment.

Source: DEST (unpublished data)

While there is logic in taking a position that students attending the same class should pay the same contribution, there will be an upward pressure on the cost to nursing students if current trends for inter-disciplinary education are supported here in Australia (see later discussion in this chapter). Also, acknowledging the cost of delivering nursing courses, we are concerned that in the current climate of 'user pays' there will be pressure to increase nursing students' contributions.

The reason nursing was allocated to the lowest contribution band was based not on the cost of the course but on the likely financial benefit to students. Nurses are among the lowest paid professional groups. Ducket (2000) provides a comparison of weekly income for nurses and other health professionals. Using 1998 data and comparing the average weekly earning, nurses earned less than either pharmacists or physiotherapists. The average weekly earning for nurses was $605.50 compared to that of the total employed in health occupations where the average weekly earning was $759.90 (Ducket 2000, p. 61).

In 2000, the average salary of newly registered nurses was $31,390 compared to $32,320 for all university graduates. It was slightly more than the average for all university graduates
in 1999 (DEST 2002b). These figures show that nursing salaries are not high compared with those of other professionals.

There has been some representation to us to recommend HECS relief for nursing students to encourage interest while the shortage of nurses prevails. This proposition was not uniformly endorsed. Some believe that to treat nursing differently from other university courses would compromise the professional status of nursing. We take the view that nursing students should contribute to their education as do other university students, but that they should be protected from the drivers to increase that contribution because of the important social contribution of nursing and the likely relative personal financial gain. Escalation in the cost to students of undertaking nursing courses would be a disincentive when they have a greater range of higher status and more highly paid career options from which to choose.

Recommendation 23—HECS for undergraduate nursing
To acknowledge the contribution that nurses make in the service of the community and the potential disincentive of increased course costs, all units that form part of undergraduate nursing courses required for initial registration should be classified at the minimum Higher Education Contribution Scheme (HECS) band.

Proposed responsibility: Commonwealth Department of Education, Science and Training, and universities

7.5 Clinical education
In its consideration of clinical education, the Review Discussion Paper posed questions about the features of effective partnerships, and the types of models of clinical experience for student enrolled and registered nurses that could be developed in partnerships between health and education. In doing so it acknowledged that effective clinical education occurs only where there are working partnerships between education and the settings of practice, whether these are hospitals, aged care facilities or community nursing services.

7.5.1 Competency development
We have already addressed some of the challenges assessment of competency pose for the preparation of nurses. However, prior to assessment, students need to develop these competencies. The two areas, competency development and student assessment, will need to develop alongside each other. Dent (2001), when discussing medicine, says that the use of clinical skills centres will be a growing part of the education and training of doctors. He sees these centres as combining a wide range of strategies including simulated venues, simulated/standardised patients, and a range of simulators from models and manikins through to realistic high-tech interactive simulators. The increasing role of audio/video technology will be essential to provide the skills needed prior to clinical placements since these are likely to become more difficult to gain as the healthcare system changes. While Dent’s comments are about medicine, they are equally relevant to nursing and suggest that the costs of preparing students for clinical placements in the future will also rise.
This is not to suggest that nursing in Australia is not already combining a range of strategies to address these issues. The use of laboratory experience and assessment in simulated settings such as the objective structured clinical examination (OSCE) are part of nursing programs in some Australian universities. Escalating litigation and a change in patient attitudes is likely to increase demand for a level of competency prior to clinical placements. These factors will not only change the nature of clinical placements but could also increase the cost to nursing education. Further, the changing nature of hospitalisation will challenge the provision of effective teaching and learning in service environments.

Medical education is beginning to document the effects of changing expectations of patients in relation to standards of clinical practice and the shortened patient stay in acute settings on hospitals as the sites of learning and teaching. The Commonwealth Fund Task Force on Academic Health Centers (2002) documents the following effects of reduced hospital stay on the education of doctors in the United States:

- The educational content of the training experience is giving way to the overarching pressure to hurry patients through the stay.
- There are increasing demands for productivity which result in reduced teaching time.
- There are increasing demands for outpatient clinical preceptors as patients move to ambulatory settings while simultaneously community physicians are less willing to participate in clinical teaching due to the pressure in these environments.

The effects of these factors on medicine are not only structural but also have resource implications. Since medical education, despite its higher status and funding, is experiencing these pressures, the implications for nursing may be even more extensive.

The importance of practice settings to the quality of clinical education is often underestimated in the way resources are allocated and expertise developed. While the cost of clinical education has been raised as one of the serious concerns facing nursing education, the tight supply of clinical places and the competition for these places act as limitations on the development of nursing education. Furthermore, additional resources will have little overall effect if the quality of the experience and the education process during clinical placement does not meet the needs of the students.

7.5.2 Resourcing clinical placements

The resource constraints around clinical placements are putting at risk the quality of the programs and making nursing education unattractive to universities. University leaders pointed out that, in order for them to offer additional nursing places, those places would need to be better funded to accommodate the costs of clinical education. This is a key issue for the future of nursing education. Compared with medicine, nursing receives much less per student per year under current operating grant arrangements since it is funded at about 59 per cent of each EFTSU in medicine. In addition, medical education is supported by grants from the Department of Health and Ageing for rural clinical schools, and from the Department of Education, Science and Training with Teaching Hospitals Grants. The Government aimed to distribute $20 million in the 2001–2002 financial year to establish rural clinical schools. Teaching Hospitals Grants for the period 2002–2004 are set at almost $5.3 million per annum.

The importance of clinical education cannot be denied. Nurses expressed frustration with what they considered insufficient practice as part of the education and training of nurses. Sometimes this was described as a loss resulting from the shift from hospital-based training to university training. Looking back to decisions to make the transfer, the Sax report (1978) also identified inadequate clinical preparation in hospital training. This is a complex area. Apprenticeship models provide excellent arrangements to learn the tasks of
nursing, but the focus tends to be diverted from education to providing service. Pure academic models provide opportunities to develop generic competencies and theory but offer little structural framework in which to apply them. New debates are about providing the 'scaffolds' (Gonzalez 2002) between the theory and practice. To achieve this, students' experiences need to be jointly designed by academic educators and practitioners and to take place in the practice environment. In the light of the changes occurring in the health care system discussed above, developing and maintaining quality education programs will be a continuing and expensive struggle.

7.5.3 Clinical education funding

A number of approaches to increasing the funding for clinical education could be considered. Assuming that operating grant arrangements to universities do not change as a result of decisions from the Higher Education Review, one approach would be to move nursing from its current position in the relative teaching cost matrix from 3 to 4. Effectively this would increase the funding per EFTU to nursing by about 38 per cent. Due to the numbers of students in nursing, this would be a considerable cost to the Commonwealth. While we believe more funding to address the clinical component of nursing is essential, we propose another option since we consider it is both less costly and more effective in promoting innovation and quality through the joint ownership of clinical education.

Recognising that collaboration will be needed to provide students, whether preparing to be enrolled or registered nurses, with quality clinical education, we suggest that additional funding should be allocated in a way that promotes academic educators and VET trainers and nurse clinicians to form partnerships. We acknowledge that some universities and VET providers may need to change their practices to work with the proposed funding arrangement but believe it is the best option for all stakeholders. To enable the development of partnerships, funding arrangements need to promote flexibility and accommodate the needs of the different States and Territories, as well to build on the developing and leading practices already occurring. Ownership of the funding by all the parties involved in the clinical education of students will promote greater responsibility on the part of the various services for the clinical experience.

Such partnerships are possible as the Commonwealth project, the National Professional Development Program, a program for teacher development attests. Teaching faces many of the challenges nursing faces in relation to the range of stakeholders at all levels but it was successful in achieving partnerships through this program. Yeatman and Sachs (1995) summarised the achievements of the project noting that 'this brilliant project in design and execution' managed 'to get people to move beyond their accustomed ways of doing things and their familiar relationships' because of 'the collaborative culture and process and the way participants feel that they own and can control the direction and pace of change'.

Our duty of care
The National Professional Development Program was a Commonwealth program established in 1993 to enhance professional development activities for teaching staff in Australian schools. The program was funded from 1994–1996. One of the objectives specified for the program was to promote partnerships between education authorities, teacher organisations and universities in the provision of professional development opportunities for teachers.

The Commonwealth Department of Employment, Education and Training (DEET) undertook a mid-term evaluation of the National Professional Development Program in 1995. It found that overall the program was an "outstanding success," with one of its major strengths being that it was particularly effective in promoting partnerships within the educational community. Guidelines for the National Professional Development Program insisted that applications for funding be based on collaborative partnerships between employing authorities, teacher organisations and universities.

The development of partnerships emerged as one of the most significant positive outcomes of the project. Key to the success of the partnerships was the contribution of members of the partnership. Workshop sessions held as part of the evaluation process of the National Professional Development Program found that the development of partnerships is not just a matter of signing up and hoping it would happen. It takes time, hard work and commitment. In particular, there is a need for the partners to be open about their agendas and to try to understand where each of the partners is coming from. In addition, it is important that each partner is treated equally and that all partners have a clear role within the project. (DEET 1995, p. 45)

We propose that a program be established to provide support specifically to clinical education. This would quarantine the funding for that purpose and allow an innovative system of management to be established in each State and Territory, one that would also encourage some sharing between universities and the VET system. Further, it would allow many of the excellent arrangements that exist to continue, with additional resources and encourage evaluation. Lastly, considering the number of undergraduate nursing students (over 22,500 in 2001), we suggest approximately $20 million a year for five years with an addition $10 million to establish and evaluate the program and to provide support for disadvantaged students. This is a relatively inexpensive option to enable some direct support to both needy students and to clinical education. Part of the funding should enable local partnerships to offer some assistance to needy students for whom the cost of clinical education causes financial stress.
Recommendation 24 — Clinical education funding

Since clinical education is an essential element of the preparation of all nurses and an area where the costs have increased to a point of being unsustainable, new quarantined funding over five years should be provided for clinical education in addition to the operating grant for undergraduate nursing courses. It should be administered through a new program, the Clinical Education Partnership Program. The program should be formally evaluated in the fourth year to assess its impact and identify any changes that may be required for its continuing operation.

The program should meet the following criteria:

a) promote State- and Territory-based cooperative arrangements between those sectors preparing nurses for initial registration and those employing them
b) be acquitted in terms of delivering quality clinical placement outcomes (to defined minimum standards)
c) prioritise partnership arrangements and contributions from all sectors involved in health and education
d) promote innovative approaches to clinical education
e) include some assistance to students, particularly for those who are disadvantaged by the high costs of attending clinical placements.

Proposed responsibility: Commonwealth Department of Education, Science and Training

7.5.4 Clinical placements

The increasing intensity of various care environments will make it difficult to accommodate the educational expectations arising from new thinking about professional education. The Victorian Universities Rural Health Consortium provides evidence of the difficulties already arising in relation to adequate and appropriate clinical placements for nurses, at least in rural areas (Mahnken 2002). In this regard, the Victorian report makes the following point:

Where university nursing schools are unable to resource and support teaching in rural settings, health services suffer a lack of capacity to function as clinical education sites (Mahnken 2002, p. 32)

In rural areas the competition between professional groups and the impact of the expansion of activity in policy and program development is changing the profile of those involved in education and research in these rural areas. According to Mahnken (2002), this is changing agreements for clinical placements between rural universities and their counterpart health services from that of local negotiation to competition on an ‘intrastate, interstate and national’ basis. While better systems for the planning of nursing clinical education may alleviate some of these strains, ultimately a more coordinated approach across the health disciplines will be needed.

The flow-on of these effects means that clinical placements will need to be maximised to enable this valuable time to be highly productive for the student. Currently there is support for a model of diverse experience for students through a range of clinical placements. There is concern that this model promotes short stays in different practice sites where the student gains no sense of belonging, the staff have no ownership of the student, resulting in insufficient time to understand the student’s needs. A number of universities are already using different approaches, such as the three summarised in Exhibit 7.4 of the Discussion.
Paper. Some of these involve the establishment of Clinical Development Units and Dedicated Education Units.

Less structured exposure, in addition to clinical placement, could be included in nursing education programs through work experience in industry. The difference between the two is that the university has no supervision responsibility for the student while on work experience. Under current funding arrangements, approved work experience in industry is H ECS-exempt for the student but does attract a small amount of operating grant to the university. A number of professions use this approach to give students real-world experience and an opportunity to build on and develop their applied knowledge. The Faculty of Engineering at the University of Technology, Sydney and the School of Accounting and Law at RMIT University are two examples of work experience in industry programs.

In the Faculty of Engineering, University of Technology (UTS), Sydney, students complete two six-month periods of practical experience (Engineering Internships) where they work with professional engineers as trainee engineer as part of the engineering degree. Students undertake their practice sessions at the end of the second year of study and again during the fourth year. ‘Bookend’ subjects around each practice session give students the opportunity to preview and review their experience in industry. These ‘bookend’ subjects make up the equivalent of an academic subject. About half of all placements are sourced from faculty industry partners. The other half are sourced from students approaching employers directly. The Industry Partnering Unit Officer for the program described the internships as the cornerstone of the degree program and that they give students a better idea of where they want their careers to go. By sandwiching these practice sessions within the degree, UTS turns experience into learning and allows students to begin their career before they graduate. The program is widely supported by industry and over 95 per cent of students in the program are employed before they graduate.

The Bachelor of Business (Accountancy), School of Accounting and Law, RMIT Business, RMIT University operates a mentored employment model as part of its undergraduate degree. All full-time students enrolled in the Bachelor of Business (Accountancy) at RMIT University undertake a three and a half or four year degree program comprising two years of full-time study, six or twelve months of program-related employment (the Co-operative Education Program) and a final year of study. Approximately 150 students from Accountancy are placed each year. Students are ultimately responsible for finding a placement, though they apply for places through the Work Integrated Learning Manager. Employers interested in securing a ‘co-op’ student register with the Program and forward a position description which is distributed to eligible students. Once appointed, the student is an employee of that organisation, paid at the relevant industry rates (approximately $24,000 to $29,000 per annum). The School of Accounting and Law employs a Work Integrated Learning Manager on a full-time basis to run the program along with a part-time administrative assistant. An academic mentor is also assigned to the students on placement. Mentors generally visit students twice during a twelve-month placement, initially to monitor student progress and later to finalise assessment. For their assessment, students investigate and report on an aspect of the operation of the organisation in which they are employed or prepare an assignment on any other topic approved by both the academic mentor and the employer. The Co-op Program has been operating in the School for 30 years and is the longest running program in RMIT. Many students choose RMIT because of the Co-op Program and a significant number of students obtain graduate employment as a result of their co-op experience.
While an increase in the amount of work experience in industry load would need to be negotiated with the Department of Education Science and Training due to its cost implications, we encourage nursing schools to examine this option, linked with the development of collaborative clinical education approaches. If this does assist in better educational preparation of registered nurses, we encourage the Commonwealth to support this development.

7.6 Specialisation

Australia lacks an agreed definition of speciality nurse and a framework for the development or nomenclature associated with nursing specialisations. As mentioned earlier, the ANF has developed competencies standards which many universities now use in the development of their courses. The lack of a common classification system makes it difficult to collect data about specialist preparation or demand. The Department of Employment and Workplace Relations (DEWR) has a system for identifying shortages but course titles do not necessarily reflect DEWR’s labels (see Table 2.2). To overcome the problem when collecting information on postgraduate students, Ogle and team (2001) revised the classification system developed in the National Review of Specialist Nurse Education (Russell et al. 1997). This revised framework includes 12 speciality categories and in addition a group labelled generic. Each of the categories has a set of sub-specialties.

The National Review of Specialist Nursing (Russell et al. 1997) recommended that the International Council of Nurses (ICN) definition of specialist nursing (see below) be adopted in Australia for use in workforce planning. However, this has not occurred.

The nursing specialist is a nurse prepared beyond the level of a nurse generalist and authorised to practise as a specialist with advanced expertise in a branch of the nursing field. Speciality practice includes clinical, teaching, administration, research and consultant roles.


The ICN also adopted four essential requirements to ensure the orderly development of specialisations in nursing. These elements are:

- the adoption of a systematic means of determining and designating nursing specialities combined with minimum standards in regard to education, experience, performance and the maintenance of competence
- the establishment of a regulatory mechanism for nursing specialists to ensure a certain level for competence
- nursing resource planning with coordination of nursing education and workforce planning as an integral part of healthcare system development.

We consider that the issues of lack of consistency in nomenclature and lack of a framework for the development of nursing specialities are a problem for both quality assurance and workforce planning. Consequently, we argue this is an issue for the NNCA. As part of its role in promoting consistency in nursing education and practice the NNCA should consider the importance of a national framework for nursing specialisations.

While there are different requirements in different speciality areas, not all nurses who work in a specialist area need to be advanced practice nurses. Those who are advanced practice nurses will require both the development of competency within the practice area and additional education. One of the current weaknesses of the system is that qualifications in
speciality nursing do not require a clinical component as part of the course. We question whether courses that do not have a clinical assessment component as well as a theoretical component should be promoted as speciality courses.

7.6.1 Postgraduate programs

Nurses use postgraduate courses for a number of different purposes. These include:

• to prepare to work in speciality areas
• to maintain competence and currency in practice
• as part of their personal development associated with lifelong learning.

Competency and currency in practice and personal development are discussed more generally in Chapter 6 because they have stronger elements of personal responsibility on the part of the nurse. The preparation for specialist practice is an important consideration for the supply of nurses needed in the workforce and it is in this context that we present the following discussion and recommendation.

Specialist nursing courses may range from graduate certificates through to masters degrees in any given specialisation. Courses preparing for specialisation can attract the same level of qualification but show considerable variation in length, the mix of clinical practice and theory and the level of involvement of the health sector in their delivery. This creates confusion for employers and provides little assurance of the quality of courses. Since universities make the decision about the level at which courses are offered, there may be only one level of qualification offered in small States with few universities. The consequences for nurses could be a reduction in opportunities to further develop in a particular area or higher benchmarks to specialisations than are generally set in the rest of the country.

Most courses recognised as sufficient for nurse specialisation are at the postgraduate certificate level and postgraduate diploma level. However, there is variation between what is recognised as a sufficient level of qualification between States, even where the nurse registration board endorses for practice in an area such as mental health. For example, Victoria only requires a postgraduate certificate, yet Queensland demands a postgraduate diploma for endorsement to practise as a mental health nurse.

While postgraduate programs are studied at different levels, for labour market purposes interest is in the way the qualification provides skills for particular specialty nursing practice. While the following discussion relates largely to university postgraduate courses that prepare nurses for specialist roles and advanced practice, there is also another important player in the delivery of postgraduate certificates—the NSW College of Nursing. Most of the College’s work is in New South Wales, but there are also courses offered outside that State (for example, in the Northern Territory).

In the DEST higher education university statistics, ‘higher degrees by coursework’ relates to masters degrees and the ‘postgraduate other’ to postgraduate certificates and diplomas. Differences between the numbers in courses and the EFTSU can be attributed to the amount of part-time study in postgraduate nursing. Table 7.3 shows that the increase across the period 1994–2001 was largely in master degrees by coursework, while the growth in postgraduate certificates and diplomas was limited to the period 1994—1996, following which there has been a downwards trend with a slight upturn in 2001. Since the latter group is where most of the courses that prepare for specialisation fall, this is a matter for concern. Although there is a slight lag, similar patterns occur for HECS places. The percentage of fee-paying units has increased for master degrees across the period from 3 to 30 and for postgraduate certificates and diplomas from 27 to 59.
The trend to fee-paying postgraduate units is noted in the Higher Education Report for the 2002 to 2004 Triennium (DEST 2002a, p. 67). The report observes that:

Institutions have had flexibility in using any funded places above the undergraduate fully funded level for either undergraduate or postgraduate coursework students. In recent years, there has been a decline in the number of funded postgraduate coursework places filled by postgraduate students. Most universities have used these places for undergraduate students and have sought to charge fees for postgraduate coursework. In 2001, some 5400 places available for study at this level were occupied by undergraduate students.

The Commonwealth is concerned about this level of under-utilisation, particularly its potential to lead to shortages and lack of professional development in professions such as teaching, nursing and other 'community service' professions.

With the introduction of Postgraduate Education Loan Scheme (PELS) many commentators suggest that the trend to fee-paying for postgraduate coursework will continue. If this is the case, there are strong arguments that some inducement will be needed to encourage enough nurses to undertake courses to meet the needs of employers for speciality nurses. There are already various scholarships offered in the States and Territories to address areas of shortage, but the approach is fragmented and the effect variable. Further, there are important areas such as aged care that attract little State government attention because States regard the Commonwealth as the main funder of aged care. Recently the Commonwealth has provided support in this area (see Attachments 6.1 and 6.2 for information on scholarships).

Some small areas of speciality also have difficulty finding courses due to the small number of students who need to undertake specialist preparation at any given time. Table 7.4 shows a snapshot of the speciality offerings within the broad categories for the year 2001. In small States and the Territories, either the expertise or level of demand will not be sufficient to.

Table 7.3 Total non-overseas 'higher degree by coursework' and 'postgraduate other' by load and payment category 1994–2001

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<tbody>
<tr>
<td>Higher degree by coursework All nursing</td>
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<tr>
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<td>1 447</td>
<td>1 484</td>
<td>1 451</td>
<td>1 586</td>
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<tr>
<td>EFTSU</td>
<td>365</td>
<td>482</td>
<td>515</td>
<td>651</td>
<td>638</td>
<td>656</td>
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<td>697</td>
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<tr>
<td>Per cent HECS</td>
<td>94</td>
<td>92</td>
<td>95</td>
<td>92</td>
<td>87</td>
<td>81</td>
<td>70</td>
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<tr>
<td>Per cent fee paying</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>13</td>
<td>18</td>
<td>29</td>
<td>30</td>
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<tr>
<td>Per cent other</td>
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<td>3</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Postgraduate other All Nursing</td>
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<td>Number</td>
<td>2 415</td>
<td>3 011</td>
<td>3 741</td>
<td>3 627</td>
<td>3 421</td>
<td>3 228</td>
<td>2 865</td>
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<tr>
<td>EFTSU</td>
<td>1 252</td>
<td>1 553</td>
<td>2 003</td>
<td>1 956</td>
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<td>1 745</td>
<td>1 576</td>
<td>1 723</td>
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<tr>
<td>Per cent HECS</td>
<td>61</td>
<td>66</td>
<td>64</td>
<td>65</td>
<td>54</td>
<td>46</td>
<td>44</td>
<td>41</td>
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<tr>
<td>Per cent fee paying</td>
<td>27</td>
<td>27</td>
<td>33</td>
<td>33</td>
<td>44</td>
<td>53</td>
<td>55</td>
<td>59</td>
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<tr>
<td>Per cent other</td>
<td>12</td>
<td>7</td>
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Source: DEST 2002b
cover many specialist areas. Indeed as Table 7.4 shows, there will even be whole categories of specialisation where courses are not offered in some States and Territories. While a number of universities have attempted to address this by offering ‘generic courses’, which provide a broad theory base that is then applied in a specific practice setting, there are problems with this approach. There is also a high level of distance education provided for postgraduate nursing courses. To address these issues a more cooperative, coordinated national approach is needed.

Table 7.4 Postgraduate specialties offered by State and Territory in 2002

<table>
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<tr>
<th>Specialty</th>
<th>Vic</th>
<th>NSW*</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
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<td>Family &amp; Child</td>
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<td>Midwifery</td>
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<td>High Dependency</td>
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<td>Mental Health</td>
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<td>Aged Care</td>
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<td>Rehabilitation</td>
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<td>Medical/Surgical</td>
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<td>Indigenous Health</td>
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<td>Community Health</td>
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<td>Research</td>
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<td>Generic</td>
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Note: Lighter boxes represent less than 15 students enrolled in the State.

Source: Ogle et al. 2002

The issues for postgraduate education are well summarised in the following statement from Southern Health in response to the Review Discussion Paper.

Postgraduate specialty courses need to be revisited. In the last few years there has been a significant increase in the number of postgraduate specialty courses being offered by universities for nurses. These developments have greatly assisted nurses to receive professional recognition from other professional groups, as well as the broader community. In some instances, this recognition has translated into better remuneration and promotion. However, one may ask at what cost to the individual, organisation and the nursing profession?

An issue aligned with the proliferation of postgraduate specialty courses is varying levels of quality. For example, it is often difficult to contextualise a course if a university is offering it to a number of health care agencies. By default, postgraduate programs have to be generic so that they can attempt to accommodate the needs of the various health care agencies buying the service. This raises the question whether it is possible for any one university to have the depth and breadth to offer a large number of specialty courses? Some universities have responded to this question by ensuring that their staffing profiles can cover the areas they teach. Others however insist on offering a broad range of courses, often without staff that possess clinical agency. They are reliant on the health care service to provide the expertise necessary to teach the course. One may argue that this is a reasonable strategy because it recognises where the specialty expertise lies.
Recommendation 25—Commonwealth assistance for speciality and re-entry courses

The maintenance of nursing specialities and re-entry programs are important in meeting labour market needs. To enable these needs to be met:

a) an audit should be undertaken of the current postgraduate coursework scholarships, including those offered by the States and Territories
b) using the audit outcome and advice from the Australian Health Ministers' Advisory Council (AHMAC) on shortages in specialised areas of nursing, recommendations should be made to the Commonwealth on the number of additional scholarships to be funded and the specialties to which they should be allocated
c) new scholarships should be offered for three years in the first instance, subject to review
d) specialised nursing areas where small numbers of graduates are needed should be identified and opportunities investigated for the contracting of these courses on a national basis
j) university-based units required for re-entry to nursing should be covered by a loans scheme.

Proposed responsibility: Implementation taskforce

7.6.2 Recognition

Until recently most nurses received little or no financial benefits for the cost of undertaking postgraduate specialist courses. Prior to the transfer of nursing education into the universities nurses received free training and often attracted a certificate allowance in addition. With the drift of specialist courses into the universities and the loss of certificate allowances, the cost of specialist education now falls to individual nurses, although there is some support for nurses undertaking courses with the NSW College of Nursing in New South Wales and the scholarships mentioned previously.

A number of Enterprise Bargaining Agreements have recently provided for the re-introduction of an allowance for qualifications in the area of practice. We support this direction and consequently recommend that employers re-introduce the allowance to encourage nurses to undertake these courses.

Recommendation 26—Remuneration for practice: postgraduate award course recognition

To acknowledge the value to the workplace afforded by nurses who undertake postgraduate courses relevant to their practice, appropriate remuneration should be provided to registered nurses who have completed a formal postgraduate award course and who are applying the related knowledge and skills in their employment.

Proposed responsibility: Commonwealth, State and Territory health ministers and other employers
7.7 Advanced practice

A nurse practising at an advanced level does not necessarily require a postgraduate qualification. Conversely, a postgraduate qualification does not ensure that a nurse will be able to practise at an advanced level. The distinction is based on the level of competency at which the individual nurse performs based on knowledge and expertise.

The following diagram from the Competency Standards for the Advanced Nurse (ANF 1997) distinguishes the different levels of practice.

Figure 7.1 Levels of practice for registered nurses

Source: New South Wales College of Nursing based on ANF (1997, p.18), response to Discussion Paper. Diagram used with permission of the ANF and the NSW College of Nursing.

There are different frameworks that can be used to distinguish these levels of practice. In their response to the Review Discussion Paper, the NSW College of Nursing summarise the current arrangements as following:

There are satisfactory frameworks in place to guide nursing nationally in relation to beginning practice (ANCI Competency Standards for the Registered Nurse), Advanced Practice (ANF Competency Standards for the Advanced Nurse, as well as many National Nursing Organisations that have developed context specific standards that articulate with the ANF standards) and the emerging Nurse Practitioner role around the country is being to develop a framework for what can be described as Expert Practice. Using these competency frameworks allows those nurses who have not had the opportunity to undertake formal award courses to demonstrate their ability to practice at advanced and expert levels through recognition of prior learning (RPL) ensuring equity and access for all Australian nurses.
7.8 Education for multi-professional teams

An increasing feature of emerging models of integrated and coordinated care is multi-professional team approaches to the provision of care to patients, clients and their carers. In order to promote successful professional teams with a client/patient focus, models of education and training that promote inter-disciplinary education and agreed practice standards for quality of care are needed.

7.8.1 Interdisciplinary education

Inter-disciplinary education and multi-professional practice should be conducted to agreed standards for quality of care. Standards development has commenced in some areas (for example, in mental health, as described in Chapter 4). Integrated and patient-focused care relies on models of education and training that give health professionals a sound grounding in the competencies required to fulfill their specific role and a clear understanding of how their roles fit with those of others within the health and social care professions. Multi-professional practice also requires clarity in legal responsibilities and boundaries. One way to assist the development of these understandings is through appropriate components of education and training undertaken on an inter-disciplinary basis, while ensuring that all professionals maintain their own identity and have the competencies necessary to fulfill their role. In this regard, it will be interesting to monitor how the National Health System (NHS) joint training across professions requirements for undergraduate health professionals progresses in the United Kingdom.

Determining appropriate mixes of shared education and training programs is essential. Currently in Australia, much of the activity in inter-disciplinary education focuses on clinical education, although there are numbers of postgraduate opportunities for professionals to share education and training developing.

One example of an inter-disciplinary approach is ALSO (The Advanced Life Support in Obstetrics), an educational program designed to help health professionals develop and maintain the knowledge and practical skills needed to manage emergencies in maternity care. The course originated in the United States in 1991 and is now owned by the American Academy of Family Physicians. It has been adapted to meet the needs of practitioners in other countries and since 2001 has been offered in Australia. The program is geared to all maternity providers including midwives, obstetricians, general practitioners, nurses, paramedics, health workers and trainees. The example below from the University of Queensland and the University of Southern Queensland is another example in the postgraduate area.
Postgraduate Program in Applied Health Science (Rural and Remote), Graduate Certificate/Graduate Diploma/Master of Applied Health Science (Rural and Remote)

The University of Queensland and the University of South Queensland have been working jointly on the development of a postgraduate program for rural health practitioners. It is anticipated that the program will commence in the first semester of 2003.

The overall objective of the program is to prepare graduates for the provision of a rural and remote health workforce model, which emphasises collaboration, networking, and referral, and which also addresses the disciplinary boundary issues that often interfere with the efficient delivery of health care to rural and remote Australians. Development of the program included the preparation and writing of 10 courses (nursing, counselling, advanced life support, emergency dental skills, limited prescribing and medication counselling, physiotherapy, occupational therapy, speech pathology, audiology and radiography) at a postgraduate level for offer by distance mode.

It has been decided that the program will be badged by the University of Queensland. However, 50 per cent of the core units for the program will be offered only by the University of Southern Queensland. Therefore, students will be required to cross-enrol to undertake those units, and will also have the option to undertake some elective units at the University of Southern Queensland within their graduate program. The project team for developing the program consider that by structuring the course in this manner, the joint contribution of both universities is acknowledged, and the rural and remote focus and experience of the University of Southern Queensland is emphasised.

The majority of courses are case- or problem-based. This will allow students to apply their specific disciplinary skills to each piece of assessment, while accounting for their level of clinical skill and their individual rural or remote context of care. This approach, while ensuring that students do not exceed their scope of professional practice, allows them to expand their knowledge of the skills of their own and other disciplines, and to apply the principles of consultation, collaboration, and referral to other disciplines to each problem. Courses are being developed in distance mode to facilitate learning by students based in non-metropolitan locations.

7.8.2 Encouraging multi-professional team approaches

Encouraging innovative approaches to multi-professional care and inter-disciplinary educational provision is also critical to building Australia's nursing workforce. As this chapter highlights, efforts are under way. They need to be expanded and strengthened to meet emerging and future needs.

Recommendation 27 — Encouragement of inter-disciplinary and cross-professional approaches to education and practice

To encourage further developments in models of care and the education that supports them, government policy, funding and decision making in the health, education and training sectors should promote and support team-based approaches in education and practice.

Proposed responsibility: Commonwealth, State and Territory health and education and training ministers
8 Organising and planning nursing work

This chapter sets out our views on principles and directions to underpin a national strategic approach to planning for a sustainable nursing workforce. Securing an adequate nursing workforce is crucial to the health and welfare of Australians. Provision of quality and safe care to the sick, aged and disabled relies on an adequate supply of a well-prepared workforce backed up by appropriate standards and resources. Australia has a skilled and dedicated nursing workforce. It represents a significant national investment in human capital—therefore, its effective and efficient management is essential, both as a matter of good stewardship of public resources and because the global market for nurses is highly competitive.

8.1 Moving forward

Past models and approaches to securing an adequate nursing workforce are unsustainable. New models of care, the demands and pressures on Australia's health, community and aged care sectors, and career choices available to the Australia workforce make change inevitable. The organisation and planning of nursing work must cater for these changing needs and circumstances.

Traditionally in Australia, the focus has been on health workforce planning designed to resolve current workforce problems, in particular addressing shortages and improving distribution. Increasingly, governments are concerned to ensure that there is an adequate supply of skilled labour in all areas of the economy and usually workforce planning has been implemented through education and training policies (Duckett 2000). Today, human resource planning for health care is receiving growing recognition and interest, reflecting greater understanding of the complex dynamics involved in ensuring an adequate, flexible and highly competent workforce. Some countries such as the United Kingdom have a long experience in human resource planning for health care while for others, like Australia, it is relatively new. In this report, we have used the term 'workforce' due to its common use in relation to nursing. However, we note that when a human resource planning approach to considering these matters is used, it is more usual to use 'labour force'.

Reliance on single solutions, such as increasing the supply of nursing places in the education and training sector or recruitment and re-entry programs for nurses who have left nursing employment, is not the answer to addressing Australia's nursing shortages and building a sustainable nursing workforce for the future. A national strategic approach is required that focuses on human resource planning, with action occurring on the following related fronts:

- work organisation
- workplace culture
- delivery of nursing
- national nursing workforce planning, which includes the health, aged and community care sector
- retention and re-entry
- supply of educational and training places
support processes and arrangements
- a professional decision making framework for nurses.

Conceptual frameworks for nursing education must be aligned with the ongoing development of the nursing workforce. The scope of practice for nurses underpins the education and training of nurses who, if they are to be regarded as professionals, must work within a professional decision making framework. While this is a key element of the way nursing services are provided, it is not developed in this chapter because it has already been examined in Chapter 5 due to its relationship with the legislative/regulatory framework.

8.2 Work organisation

Healthcare delivery involves a complex and dynamic set of systems and processes. As discussed in Chapter 4, the variety of places and settings where services are delivered is increasing, as are the range and types of services provided. Since these trends are likely to continue, they pose challenges for nursing work organisation.

Nursing work organisation is context-dependent because it occurs in a range of different settings that provide nursing care to different client groups. Within these different contexts, work organisation must recognise the spectrum of care comprising nursing work, from trained care assistants through the various levels, and must recognise the appropriate mix of competencies required across the spectrum to provide the community with quality and safe services.

8.2.1 Maximising value—resources and professional capacity

Work organisation must ensure the best use of available nursing resources and must ensure that nurses are able to practise to their full professional capacity within particular care contexts. Often ‘best use’ is considered in financial terms only, not in terms of cost effectiveness. For example, concerns are expressed about the relative high costs of registered nurses, with attention often placed on the wages and salaries bill nurses represent to hospitals and other health and care services and on ways to employ other types of care workers as substitutes.

Overseas research in the acute care setting, however, indicates that a ‘rich skills mix’ in the delivery of care, comprising a high proportion of registered nurses, may not be more expensive than a mix with a large number of unregulated workers. O’Brien-Pallas, Thomson, Alksnis and Bruce in The economic impact of nurse staffing decisions: Time to turn down another road? (2001) present evidence showing that the right number of nurses and right skill mix has cost benefits. They report that understaffed hospitals had higher costs than hospitals employing more care givers, that reduction below a certain proportion of registered nurses increased costs, and that adequate nursing levels can contribute to cost reductions. Fagin (2001) also reports a study by Sovie in 1999 that found that the cost drivers were fewer registered nurses and equivalent staff and hours worked per patient day, not the proportion of registered nurses.
Recommendation 28—Work organisation

Because the nursing workforce (including trained care assistants) contains a range of experience and skills, and because it needs to adapt to an evolving care environment, work organisation throughout the health, aged and community care sectors should:

a) constantly seek to achieve the most effective and efficient use of the total nursing workforce (including learning from best practice elsewhere)
b) ensure that skills and expertise are matched to the work required in the particular workplace
c) take account of the interrelationships with other health professionals
d) ensure that nurses are encouraged to practise to their full professional capacity.

Proposed responsibility: The NNCA and employers

8.2.2 Responsive to change

The organisation of nursing work must be dynamic with capacity to respond in timely and effective ways to changing community needs. Models of nursing care will change as health, community and aged care systems change, often in response to shifts in attitudes or new technologies. Models of nursing care and practice should be continually monitored, reviewed and evaluated to ensure their appropriateness, cost effectiveness and relevance. New models of best practice should be developed and tested to address changing needs and circumstances.

8.2.3 Guiding principles

Organising nursing work requires:

- understanding and documenting nursing work—that is, the range of nursing work required today and in the future across the range of health, community and aged care settings
- understanding the impact of the different levels of nurse on the effectiveness of the system in terms of patient/client outcomes
- specifying the competencies needed across the range of settings to meet those needs—that is, the standards that different components of the nursing workforce must meet in order to practise
- balancing the mix of skills, expertise and experience to the work required across the range of settings and nursing care needs
- determining the type of workforce required to best meet the need for nursing care, from trained care assistants through to the highest levels of advanced practice.

8.3 National approach and leadership

Models of work organisation have developed on a State and Territory basis or by particular groups within the nursing profession, reflecting service delivery arrangements and particular professional interests. A national strategic approach across the nursing workforce is vital. The proposed National Nursing Council of Australia (NNCA) is best placed to provide national leadership on nursing work organisation. It should undertake regular reviews of nursing work organisation in Australia, monitor developments and practices, and report on examples of best practice in the organisation of models of nursing care.
8.3.1 Workplace culture
A supportive workplace culture that takes account of professional and personal needs and aspirations is essential to securing an adequate nursing workforce.

Nurses' professional needs and their expectations of the workplace were a recurring theme in Review submissions and consultations. Nurses want:

- to have their professional skills and knowledge recognised
- to have time to 'care' for their patients
- to be supported in professional development
- to have some control over their work
- family-friendly workplaces
- safe environments and better remuneration.

Nursing students anticipate completing their studies to enter a workforce that recognises their qualifications and experience and in which there will be mutual respect and teamwork. Indeed, as one group of nurses and nurse educators noted 'they often find they belong to a profession often controlled in a paternalistic manner and one that is not held in high regard by other "health team" members'. Additionally, 'upon entering the profession the reality they encounter is one of endless shift work, low pay, horizontal violence, social isolation, risk of injury and disease'. (Senate Community Affairs References Committee 2002, Submission No.51).

8.3.2 Positive work environment and professional recognition
The importance of a supportive work environment is a recurring theme in the research literature and the Review submissions and consultations. Many nurses feel that their work is not valued, that they do not have the power to influence the system in which they work, and that their high levels of clinical judgment and decision making are not recognised in the workplace. Many nurses consider that nursing shortages compromise their capacity to function as a nurse and provide care. Long and inflexible hours and supervision of casual workers and those with little or no education and training were identified as contributing factors.

Current shortages have created a climate that often results in aggression between staff, and hostility from families and patients. A number of submissions raised the issues of cost cutting or rationalisation of healthcare funding impacting adversely on nursing. Support services to nurses (supply, clerical, human resources, cleaning and food services) have been reduced with experienced nurses spending more time undertaking tasks that take them away from delivering nursing care.

Pearson and colleagues (2002), in a recent review of recruitment and retention of nurses in residential aged care for the Commonwealth Department of Health and Ageing, identified the importance of a supportive work environment in improving the retention of nurses by minimising stress, burnout, low morale and low organisational commitment. The most powerful emerging theme was profoundly low job satisfaction felt by nurses. They conclude that simplistic cosmetic tinkering will be ineffective. Substantial structural changes are required to begin to rectify the poor working conditions and low morale of the existing workforce. Further, they noted the impact of documentation load in aged care—a theme we often heard during the Review consultations. Consequently, we make the following recommendation in the interests of encouraging nurses to remain in aged care.
Recommendation 29—Aged care nursing
To ensure that residents of aged care facilities have access to quality nursing care and that nursing in the aged care sector is an attractive option for nurses, Commonwealth aged care responsibilities and funding arrangements should enable professional nursing time to be focused on residents in aged care facilities by separating professional nursing documentation from the funding tool.

Proposed responsibility: Commonwealth Department of Health and Ageing

8.3.3 Multi-professional team work
A positive work environment involves the promotion and fostering of multi-professional team approaches to care provision. As noted in Chapter 4, increasing features of emerging models of care in the health, community and aged care sectors are integration and care coordination. This requires both new approaches to education and training of nurses and other health professionals and changes in the work environment to foster multi-professional teamwork.

8.3.4 Occupational health and safety
Occupational health and safety was a key concern identified by Review respondents. Safety was seen as directly related to the increasing pressure and stress nurses are facing and the inherent risks and dangers involved in working long hours and large amounts of overtime. Hospitals and nursing homes are areas within the health and aged care sectors that most commonly experience injuries and subsequent workers’ compensation claims (Submission from Queensland Nursing Council). Many submissions called for employers to ensure the safety of nurses in the workplace and when leaving work.

In research undertaken for the Review on what nurses are doing every day in various practice and work settings and the challenges they are facing, Jones and Cheek (2001) concluded:

Of grave concern throughout the study has been the degree to which nurses have shared experiences of aggression and/or violence in their practice area. Aggression can be verbal abuse from other staff, doctors and patients and/or their family members or it can be threat to harm, and at times physical assault. Many nurses expressed concerns for their personal safety and those in their care. Some workplaces within the study do not have readily available on site security or adequate systems of security. A significant challenge expressed by many nurses was the lack of support provided by management for safety and a sense of feeling ill-prepared to anticipate and manage escalating events.

8.3.5 Need for action
It is clear that nurses will not continue to work in environments that take little account of their professional and personal needs and aspirations. Research on why nurses are leaving full-time employment suggests that unless the working environment is such that it meets nurses’ needs, they will choose either to move to casual employment or leave nursing. Nurses today have a range of skills in high demand in the labour market and, combined with higher levels of education, they are in an excellent position to choose from a range of other career options.

A culture change is required. Organisational and other barriers must be overcome and an environment created where professional nursing practice is valued and supported over time.
We acknowledge that this is not an easy task and that simplistic solutions will not bring about sustainable change.

New approaches are required including ways to encourage health, community and aged care organisations to adopt practices that involve nurses in decision making, promote collaboration among health professionals, give nurses the opportunity to pursue continuing education and organise care to improve patient outcomes. Investment in the nursing workforce in these ways is crucial to the health and welfare of all Australians and will enhance the nation's ability to respond to public health needs and crises. It is essential that all players work together on these matters, that innovations to bring about structural changes are encouraged, and that approaches and results are shared.

**Recommendation 30 — Workplace culture**

To develop a constructive workplace culture, management in all health, aged and community care sectors, in consultation with staff, should establish and implement a suite of policies that encourage:

a) support for professional development
b) a positive work environment in which staff feel valued and are able to make their full contribution
c) multi-professional teamwork
d) workplace safety and cultural sensitivity
e) a work/life balance.

**Proposed responsibility:** Commonwealth, State and Territory health ministers and other employers

**8.4 Planning the nursing workforce**

Achieving a balance of supply and demand in the health workforce is difficult for several reasons: long lead times for education and training of health professionals, low mobility of health professionals, and the impact of rapid technological change on demand projections. Low mobility of the nursing workforce is a particular feature of some rural environments.

**8.4.1 Australian health workforce planning**

National self-sufficiency has been the main policy goal and the mal-distribution of the workforce between urban and rural areas has been a constant challenge to policy makers. These challenges are likely to be a continuing part of policy developments since there will always be locations and communities that are less attractive employment settings.

Health workforce planning has sought to minimise divergences between supply and demand. Duckett (2000) has observed that Australian health labour market planning has tended to influence supply, with demand being viewed as exogenous. As Duckett (2000) points out there are real costs associated with imbalances. Under-supply results in poor access, unmet need, potentially poorer health outcomes, overworked and stressed workers (which may make the profession or area unattractive and further reduce supply), and increased costs of alternative provision. Over-supply may lead to unnecessary costs in education and training.

A primary focus of planning has been the medical workforce, with planning undertaken through the Australian Medical Workforce Advisory Committee (AMWAC). However,
attention is shifting to other health professionals, with the nursing workforce now a priority concern. This work is being conducted by the Australian Health Workforce Advisory Committee (AHWAC), which was formed in 2000 to provide a national approach to human resource planning for other health professionals including nurses. This is an important national development. Previously, nursing workforce planning was undertaken largely on an individual State and Territory basis.

8.4.2 Australian nursing workforce planning

Initially, AHWAC is concentrating on future workforce supply for critical care nursing and midwifery. A similar approach to that used by AMWAC to estimate the number of medical practitioners required to meet but not exceed future population requirements is being adopted. The approach covers workforce supply and workforce productivity (supply side measures), population requirements for services (demand side measures) and matching future supply and requirements. It should be noted that this methodology is currently under review.

AHWAC is also conducting another project, Profile of the Nursing Workforce, to establish a national agreed baseline profile of the nursing workforce in different settings, sectors and jurisdictions. Unfortunately, the findings were not available for consideration in this Review. The project is due to report in October 2002.

In the past, States have put considerable work into nurse workforce studies (general and specialist workforce projections and surveys to investigate issues around the successful recruitment and retention of nurses) (Johnson & Preston 2001). Much of this work has been limited by data quality and methodology problems. It is important, however, that lessons learnt from this work are drawn upon in current and future nursing workforce planning initiatives.

For this Review we commissioned two studies: Job Growth and Replacement Needs in Nursing Occupation (Shah & Burke 2001), and The Nursing Workforce 2010 (Karmel & Li 2002). The projects are based on different methodologies. Both projects identify the difficulty of capturing a picture of all paid workers involved in nursing work. Both relied on data from the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics Labour Force surveys and the Labour Mobility survey for 2000. The implications of the findings of these studies for supply are discussed later in this chapter.

8.4.3 International developments

Internationally, the Organisation for Economic Co-operation and Development (OECD) has identified an interest in exploring human resource policies for healthcare that best contribute to efficient and effective delivery of health services across OECD health systems. The project recognises the importance of health workers in timely delivery of good quality health care, that they represent a significant share of OECD workers and population, that healthcare is an expanding area for employment and that OECD countries are facing various labour market scenarios. Some predict an over-supply of doctors or nurses or both. Others expect shortages either in general or in specific regions or specialisations. The project, Human Resources for Health Care, will focus on physicians and nurses.

8.4.4 Supporting information and research

Timely, reliable and comprehensive workforce information is an essential planning ingredient. Workforce information on nurses is collected periodically by State and Territory nursing registration boards in conjunction with renewal of registration. Data is processed
electronically by State health authorities. In addition, every two years the AIHW conducts a survey of the nursing workforce in Australia at the time of registration renewal. The AIHW draws together information from these and other sources in a national nursing workforce publications series. There are long lead-times associated with collection, processing and release of nursing workforce information. Similar problems are experienced for other areas of health workforce. They relate to the use of administrative sources across eight jurisdictions. As well, differences in definitions and nursing nomenclature across jurisdictions hinder development of national time series and comparisons. The AIHW is pursuing ways to improve the currency and comparability of nursing workforce information for Australia.

8.4.5 Areas for improvement

Review submissions, consultations and research have highlighted several problems that need to be addressed in improving Australian nursing workforce planning. Data problems include:

- lack of timeliness in results
- inadequate response rates
- inconsistencies in definitions and nursing nomenclature across jurisdictions
- lack of differentiation in some collections between categories of nurses
- other data management problems.

Methodological problems focus on the inherent difficulties associated with workforce projections and related studies and contestability of results. Structural problems are evident in conclusions that often have little influence on or relevance to policy or practice and that lack strategic policy focus. The workforce needs of the private sector and community and aged care sectors are often overlooked. Many respondents commented on the lack of effective structures or means for feeding nursing workforce needs into the supply of education and training places loop, lack of a national picture, and lack of understanding of particular needs such as those for specialist nurses.

8.4.6 Future needs

Numerous reports have emphasised the need for a national approach to nursing workforce planning strategies and processes. A national approach to addressing nursing workforce planning is essential to securing a sustainable workforce for the future. AHMAC and AIHW play important roles and the establishment of the AHWAC is a significant development in attaining a national approach.

Effective national nursing workforce planning requires:

- timely and reliable information and research
- a national nomenclature for nursing and those who support nurses in nursing work
- reliable and robust methodologies
- consideration of the nursing workforce across the health, community and aged care sectors including labour market pressures, career pathways and multiple entry points of nurses
- integration with other aspects of health workforce planning
- strong linkages with the education and training sector and supply of education and training places
• arrangements to establish priorities in consultation with stakeholders
• establishment of a baseline profile of the nursing workforce across the health, community and aged care sectors
• examination of both demand and supply factors
• measures and methods to monitor and assess the impact of workforce planning strategies
• measures and methods to assess patient outcomes resulting from nursing work
• capacity to respond to changing needs and circumstances
• capacity to take account of local and special needs
• monitoring and review arrangements
• regular evaluation.

Recommendation 31—Workforce planning and data
Workforce planning is a vital component of future policy processes. It needs to be based on reliable valid data. Consequently the following are supported:

a) AHMAC’s ongoing work on nursing workforce planning which should proceed as a matter of priority to determine:
   i. the current size and composition of the nursing workforce—care assistants, enrolled nurses, registered nurses (general and specialist), and nurse practitioners—in the community, health and aged care sectors
   ii. the current and projected requirements of the nursing workforce in accordance with the priority determined by AHMAC following consultation with the NNCA

b) The ongoing work of the Australian Institute of Health and Welfare (AIHW) to establish and analyse data on the nursing workforce (including action to improve its currency) should proceed as a matter of priority.

Proposed responsibility: Implementation taskforce in consultation with AHMAC

Recommendation 32—Health workforce research funding
Australia’s workforce planning needs to be based on an integrated view of the workforce, developed using quality research tools. At the same time, recognition of the unique contribution of particular professions, such as nurses, must be understood. To promote this approach:

a) funding should be provided for further development of a robust methodology for all health workforce planning (including nursing), with consideration being given to the establishment of a research centre to undertake this work. Funding should be provided for five years in the first instance, subject to review
b) the methodology employed should draw on overseas research to further develop nursing indicators that are applicable in the Australian context.

Proposed responsibility: Implementation taskforce
8.4.7 Retention— the key

Evidence from a variety of sources (Shah & Burke 2001, Pearson et al. 2002, and Karmel & Li 2002) clearly indicates that increasing the supply of nursing education and training places will not address Australia's nursing workforce needs for the foreseeable future. This was a constant message in Review submissions and consultations. Losses of recent graduates are reported to be high. Research on nursing workforce projections by Karmel and Li (2002) shows that the highest exit rates are for 19–21-year-old nurses and that any increase in the overall exit rate of nurses will have a significant impact on registered nurse numbers in the near future. Nursing is competing with a wide range of career options for women, the group most likely to be nurses. There are long lead-times in nurse education and training. Retention of highly skilled and professional nurses in the health, community and aged care workforce is the key factor in ensuring a sustainable nursing workforce for the future.

The disappearing questions

Retention of nurses and why nurses leave nursing are not new questions. A number of studies have examined the various aspects of nurse education and nursing that have made it difficult to retain nurses, and have advised on retention strategies. Studies include Ministerial Taskforce: Nursing Recruitment and Retention (Queensland Health 1999), Nursing Recruitment and Retention Taskforce – Final Report (NSW Health 1996b), Attracting Nurses Back to the Nursing Workforce (Health Department of Western Australia 1997), Factors influencing the recruitment and retention of nurses in rural and remote areas in Queensland (Hegney et al. 2000) and Nurse Recruitment and Retention Committee: Final Report (Department of Human Services [Victoria] 2001).

The reasons nurses leave nursing are well documented (Aitken et al. 2001) and consultation with nurses and nursing organisations during the Review confirmed many of them. Most relate to different aspects of working conditions such as:

- lack of autonomy
- safety
- nurses' capacity to function professionally as nurses with current staffing shortages
- recognition of nurses' skills and knowledge
- child care
- shiftwork
- conditions of pay.

In their recent study on recruitment and retention of nurses in residential aged care, Pearson and team (2002) indicate that most nurses who have left the aged care nursing workforce have done so for personal or family reasons, with a significant number also citing low pay, low staffing levels, excessive documentation and poor status.

The matter of nursing retention will not disappear. Some action is being taken in parts of Australia and parts of the health, community and aged care sectors to address reasons for leaving and to encourage nurses to stay in nursing (see Attachment 6.1). A coherent national strategy and national action are vital.

The price of inaction is high. There are real social, economic and personal costs associated with nursing losses and inaction. An education and training supply strategy will be of little effect if retention is not addressed. Each highly skilled nurse lost to the system will take at least four years' investment in education to replace. The costs of high turnover are enormous. For example, the Northern Territory Health Service (2001) estimates that the replacement cost for one year of Registered Nurse Level 1 (RNL1) turnover for Alice...
Springs hospital was $300,000. Moreover, the small proportion of the workforce aged less than 30 years of age means that those who might be interested in a long-term career in nursing will be sourced from fewer nurses than in the past. Loss of much of the educational expertise in the clinical environment means that some students are not receiving good quality learning experiences in that environment. The system is already showing signs that it is unable to support the demands on clinical education that current numbers of students are making. New graduates are unable to complete a transition period without facing the demand to take on high levels of responsibility while completing graduate programs. Producing a specialist nurse builds on the foundation of initial education, training and experience. As generalist nurses are in short supply, taking from their ranks to produce specialist nurses only shifts the problem of shortage.

If employers wish to encourage the retention of new graduates, they could offer support with the payment of HECS. As an incentive, this would provide encouragement not just to study nursing but to practise nursing and increase the attractiveness of a career as a nurse. Arrangements between employer and employee are particularly powerful in this regard. Incentives may take many forms, and may actually decrease the costs to employers of the high turnover and replacement evident in some places. If employers chose to assist with the payment of HECS, they could take advantage of the 15 per cent discount for voluntary repayments of $500 or more.

8.4.8 Re-entry

Re-entry strategies focus on addressing nursing shortages by tapping into a resource of inactive nurses. Review respondents identified promoting the recruitment of nurses who have left the profession as another important strategy for addressing nursing shortages. Provision of refresher and re-entry facilitates the return of nurses. Some States and Territories have embarked on significant re-entry recruitment and training efforts in recent times (see Attachment 6.1).

Concerns about refresher and re-entry courses seldom arose during Review consultations. Matters that were raised included the costs of courses (especially when delivered by universities), lack of flexibility for those with family or work commitments, and the need for nurse registration bodies to have a process to ensure standards of these courses.

Re-entry strategies are enrichment strategies. They recognise the richness that experienced and older workers bring to nursing teams and workplaces and the benefits of combining nurses of different ages and experience into teams.

Pearson and team (2002) examined a range of matters associated with recruitment of nurses who have left the Australian residential aged care sector. Following a review of the available literature on nurse re-entry programs and courses, the authors noted that:

- Nurse re-entry courses have been employed in a variety of settings.
- Nurses and employing institutions recognise the benefits of undertaking a short period of time.
- The returning nurses have special needs that must be attended to in order to produce the best results.
- Course flexibility, staff encouragement and support are of paramount importance.

Courses provide additional benefits to participants including regaining self-esteem and confidence in practice. Pearson and colleagues concluded that re-entry courses provide a cost-effective and prompt solution; however, the number of nurses graduating is low. They developed a model re-entry training program in aged care and recommended the establishment of a national nurse re-entry program in aged care to address current deficiencies.
We support the broad thrust of these recommendations and observe that they are part of a set of recommendations before the Commonwealth Department of Health and Ageing aimed at addressing recruitment and retention of nurses in residential aged care. While nurse re-entry programs may provide a cost-effective and prompt solution to nursing shortages, they should not be viewed as the sole solution.

8.4.9 Supply
The current difficulties in attracting and retaining nursing staff need to be addressed immediately. A major investment in the retention of the existing workforce, recruitment of nurses not currently employed in nursing, recruitment from overseas and investigations about how work could be better organised are necessary. Until there are improvements in these areas there will continue to be problems with the provision of clinical education and the transition of new nurses into the workplace, as well as problems in attracting new members to the profession and retaining current members.

There are three recommendations dealing with increases in the numbers of places in nursing courses and training for care assistants (Recommendations 33–35). Those related to nursing (Recommendations 33 and 34) should be read as contingent on progress in the areas of retention, immigration and work redesign. Additional numbers of nursing places above those recommended in the following recommendation (Recommendation 33) should be based on research about the appropriate numbers and skill mix for evolving models of care.

A number of studies undertaken recently support the view that the current levels of supply of registered nurses from universities are insufficient to meet demands. These include the work commissioned by the Australian Council of Deans of Nursing (ACDON), yet to be published, the Shah and Burke (2001) report and the study of Karmel and Li (2002), both of which were commissioned for this Review. The trends in relation to trained care assistants are confused due to the lack of a single nomenclature and classification grouping. Some are identified within the nursing workforce by AIHW, others are in completely separate workforce categories. Enrolled nurses, while currently in shortage, do not appear to present the same difficulties in terms of supply as registered nurses under current work organisation.

These three studies all use different methodologies based on different assumptions. All the studies provide projections which ‘are constructs based on certain assumptions and their use is in stimulating discussion on the issues, not in predicting the future’ (Karmel and Li 2002). The ACDON report deals specifically with university graduates. The Shah and Burke (2001) study examines job growth and replacement needs. They project from 2001–2006 net job openings of 21,100 for registered nurses, 1,900 for enrolled nurses, 2,900 for personal carers and assistants in nursing and 20,500 for aged and disabled person carers.

Registered nurses
Karmel and Li make the following observation based on their projections:

What is stark is the size of the disparity between the demand and supply projections for registered nurses. In 2010 the difference is of the order of 40,000 registered nurses. That is, the current output of nurses is insufficient to maintain the current workforce (assuming the reasonably benign exit rates of 1995-96 are maintained), let alone cope with the extras demand that we would expect demographic factors to bring.

(Karmel and Li 2002)
Consequently, we argue for an increase in funding for undergraduate nursing load, initially for two years, until further work on both new models of work organisation and retention strategies can be assessed. We suggest an increase of 5–6 per cent each year. There are currently difficulties finding clinical placements for some students and this needs to be considered when increasing places in undergraduate nursing programs. A faster output of graduates can be achieved by accepting into the program people who can gain advanced standing or credit toward a nursing degree. It is therefore in the interest of the workforce to focus additional places on this group, rather than on recent school leavers.

In the longer term, strategies to increase the numbers of graduates with nursing degrees need to be linked to the demands of the health, aged and community care sectors and the capacity of the system to provide quality education including clinical education. Retention of new graduates by providing appropriate transition support is also essential. Commonwealth commitment to additional funding for undergraduate nursing education after the initial two years should be considered within the context of more reliable workforce data and other strategies to encourage the retention of the current nursing workforce.

Recommendation 33—Commonwealth funding for additional undergraduate university places

An increased supply of registered nurses is essential due to current shortages and the rapidly ageing nursing workforce. An initial short-term measure to achieve this outcome should include the following actions:

a) A benchmark for nursing commencement load based on the 2002 equivalent full-time student units (EFTSU) for non-overseas nursing commencements in each university (including direct-entry midwifery) should be set as the target for the following two years, with under-target load to be re-distributed to universities which have provided additional nursing EFTSU above the 2002 benchmark. The results to be reviewed after two years.

b) An additional minimum of 400 EFTSU for undergraduate nursing commencements should be provided for two years, beginning if possible in 2003, on the basis that:

i. universities nominate for the additional places and provide evidence that this is an increase on the previous year’s total EFTSU for non-overseas nursing commencements

ii. universities are able to supply quality clinical placements for all their nursing undergraduate students

iii. the places are targeted to students who are able to gain advanced standing (such as enrolled nurses who wish to upgrade) and current undergraduates or graduates who wish to transfer to nursing.

Proposed responsibility: Commonwealth Department of Education, Science and Training
Expansion of enrolled nurses and VET-in-schools

Since both the school sector and the vocational education and training (VET) sector are State and Territory responsibilities, the following recommendation relies on the support of the State and Territory education portfolios. In recent years there has been an expansion of the number of commencements in enrolled nurse training across Australia (see Table 2.9). Universities also report high levels of interest in enrolled nurses wishing to complete nursing degrees. We encourage this pathway because it both provides career advancement opportunities for enrolled nurses and a quicker supply of registered nurses in times of shortage.

As noted in Chapter 2, there has been a shift in the composition of the nursing workforce away from enrolled nurses to registered nurses in some settings and care assistants in other settings. Karmel and Li (2002) indicate that projections for enrolled nurses show a reasonable balance between supply and demand. They also make the point that there will need to be structural changes in work organisation. Key to these changes will be the enrolled nurse. An increase in supply of enrolled nurses and in the numbers of those upgrading to registered nurses is necessary to support this change. Enrolled nurses are currently in shortage in all States (see Table 2.2).

A range of training options for enrolled nurses is available. One, traineeships, offers potential for rural and regional areas in particular. We reported in our Discussion Paper that there were trainees in Victoria and Tasmania in 2001 and have also documented an example of a program that uses this model of training in Port Pirie in section 6.3.1 of this report. To support these processes as well as to build the educational capacity in different services, we propose that nurses be offered workplace trainer and assessor courses.

Further, to encourage interested senior school students in a course related to nursing we support the development of VET options based on the Community Services and Health Training Packages. These offer school students alternative pathways into nursing, which may be attractive to some students since they do not rely on a sufficient TER to gain university entry. The success of some of these initiatives is demonstrated in section 6.3.2. Although it is possible in many States to build these options into the school curriculum, we found only one example where the system had developed an option that could then be accessed by all schools and this was in South Australia. This option is the Care and Health Industries Pathways for Schools, which is also explained in section 6.3.2. We encourage other school curriculum authorities to assist the expansion of VET courses based on the Community Services and Health Training Packages to broaden the options for those students interested in this essential industry.
Recommendation 34 — Expansion of opportunities in VET and VET-in-schools

States and Territories should expand opportunities for entry to enrolled nursing and occupations that do nursing work by:

a) providing additional training places for enrolled nurses to replace those upgrading to registered nurse within the State/Territory, and to meet shortages of enrolled nurses
b) promoting employment of student enrolled nurses through models of education and training such as traineeships
c) working with the Commonwealth to expand traineeships in rural areas as an entry to care work and nursing
d) supporting the expansion of VET-in-schools programs based on the Community Services or Health Training Packages
e) offering workplace trainer and assessor courses to nurses and recently retired nurses willing to assist in training or supervision of student nurses or trainees, particularly those in rural areas.

Proposed responsibility: Commonwealth, State and Territory ministers for education and training

Training places for care assistants

In earlier sections of this report we identified the need for care assistants to have appropriate training for the work they do. The following recommendation supports Recommendation 7, which requires all workers without relevant recognised training who are employed in care of patients/clients to have a minimum competency standard of Certificate III from the appropriate Community Services or Health Training Package.

While there has been substantial progress in the number undertaking training, particularly in aged care (see Table 2.10), the growth has not been even across all the States and Territories. Table 8.1 compares enrolments in the various certificates by States and Territories. The numbers enrolled in Certificate III in aged care work are most encouraging, particularly in Victoria and South Australia. The enrolments in disability and community work certificates are far lower than those in aged care work. This suggests there will need to be a concerted effort in these sectors.

Table 8.1 Enrolments in Certificate III in Community Services training packages across Australia for 1999, 2000 & 2001

<table>
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<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
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<td>Aged care work</td>
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Source: NCVER 2002 (unpublished data)
We recognise that there are workers in all of these industries with long-standing experience through which they have developed competencies at the level required to perform their work. Those workers should be able to be assessed in the workplace rather than undergo unnecessary training. Our recommendation recognises this and suggests that part of the strategy should be to increase the number of workplace assessments as well as expanding training places. The strategy will require negotiations with the aged, community and disability care sectors, particularly as there is little known currently of the numbers of workers who will require this up-skilling.

Recommendation 35 — Training places for Certificate III
To ensure that those workers involved in direct care work in the health, aged and community care sectors achieve a level of at least Certificate III in the appropriate Community Services or Health Training Package by 2008, a strategy should be developed to expand workplace assessment and the number of training places for Certificate III in the appropriate training packages.

Proposed responsibility: Commonwealth, State and Territory ministers for education and training

8.5 Support processes
Effective support processes are important elements of a culture and environment that values nursing work. The need for improvement was a common theme during Review consultations. Review respondents sought improvements on two fronts: effective leadership in workplace management and in clinical settings, and effective leadership in promoting and representing the nursing profession.

8.5.1 Leadership and management in the workplace
Leadership, staff development and analysis of values and beliefs must be considered in nurse education today. Jones and Cheek (2001) report that both registered nurses and enrolled nurses across this study required management and, to some degree, leadership skills:

You have to have management skills … you've got to know about project planning, you've gotta know about quality improvement, you've got to know about budgeting, you've gotta know about employee human resource management, staff training, those are all really important elements … I'm trying to organise the police to come and do safety awareness for our nurses, now that's not particularly my role, because I'm community. But because you know, the assaults and everything on nurses, I'm actually liaising with the local police...

The current healthcare environment is complex, with management tools, financial systems and human resource allocation part of most everyday practice for nurses. Nurses are leaders of teams within given settings— for example, enrolled nurses are seen to lead teams of trained care assistants in aged care settings, they manage stock and finances linked to a general practice or theatre and are required to manage not only their time but to maintain efficiency with the system. Registered and enrolled nurses expressed the need to have good time management skills to progress through the requirements of the day and to meet the needs of those in their care or those to whom they provide a service.

Currently, there is a diversity of courses available. Programs include postgraduate programs in functional nursing specialties, leadership and management programs and initiatives such
as the ICN Leadership for Change, Health Leaders Network and others (see Attachment 8.1).

National collaboration between the education and health sectors in the development of educational postgraduate programs to prepare nurses for clinical leadership and management is vital. Strategies should cover:

- mentoring and coaching, with senior people helping young staff to progress
- making available programs to develop the competencies required for leadership, management and human resource skills
- providing opportunities to participate in policy development.

We also note the development of work environments where nurse leadership is visible and supportive of staff. One example is magnet hospitals where positive characteristics of clinical nursing include autonomy in practice, status within the organisation and collaboration.

8.5.2 Professional leadership at all levels

Leadership and representation of the Australian nursing profession nationally and internationally also plays an important role in the valuing of nursing. Development of responsible and responsive policies relating to nursing practice requires drawing on the expertise and knowledge of the nursing profession. Many submissions commented on deficiencies in current policy advice arrangements.

**Recommendation 36—Nursing leadership and management**

For nursing leadership and management to be enhanced:

a) governments should ensure improved representation of nurses on bodies which advise on both health and health education issues, so as to use more fully the expertise and knowledge of the nursing profession

b) workplaces should recognise and support the development of future nurse leaders and managers, using initiatives such as

i. mentoring and coaching, where experienced staff help younger or less experienced staff to develop and progress

ii. involvement in policy development and implementation

iii. provision of programs in areas such as human resources, financial management and policy development.

**Proposed responsibility:** The NNCA
9 Conclusion

In this report we have attempted to share much of the innovation, energy and commitment we have seen across Australia. There are examples of some of this innovation that we hope will affirm the dedication and creativity of many nurses at all levels both in the practice and education sectors. National agreements in relation to the Australian Nursing Council Incorporated (ANC1) competencies and the development of the National Nursing Organisations are a tribute to the way nursing has progressed towards a national perspective.

In addition, it is clear that the policy framework for promoting responsiveness in education and training is already in place. There is also evidence that, from school to postgraduate education, students are entering the nursing career pathway at various places and are able to make a wide range of career transitions. While there are still some areas for improvement, we should celebrate the advances that have been made in this area in a very short time.

Considering the size of the nursing profession and its key role in the health, aged and community care sectors, nursing has received little attention as a national issue. Until recently, nursing as a profession has been largely invisible in health policy debate and research priorities. Nurses themselves have had little opportunity to advise on policy issues and evolving roles in systems of care. Nurses’ involvement in decision-making, particularly in large hospitals, has decreased over time under corporate management structures.

9.1 The Review’s approach

Our approach in the Review has been to recommend measures that establish supporting structures to further develop national cohesion on nursing, to promote flexibility, encourage innovation and share the successes and ideas that are emerging through local initiatives. Further, in our recommendations we acknowledge that there are some areas where more strategic approaches are required. There are also areas that will require additional funding and other resources.

We are convinced that a fragmented approach to the resolution of some of the current problems will not be effective. Further, setting a national direction for the future will require a more integrated planning process than has been evident in the past. We recognise the enormity of drawing together different portfolio responsibilities and different levels of government but, as is documented in various places in the report, governments have already developed models that demonstrate this is possible. While it is essential that this level of policy and planning agreement underpins future developments, it is also essential that local partnerships, including those between education and the various service sectors in which nurses work, continue to develop. In many cases the foundations of this are already in place. Building from isolated examples into mainstream activity is the challenge that we now need to pursue.

The demand for nurses

The background to this Review was the pressure experienced in hospitals and aged care facilities to find enough nurses to meet the requirements of those services. This challenge could be even greater in the future, due to the effects the ageing of the population will have on the competition in the labour market and the need for more nursing support services to
respond to the increasing levels of disability that accompany ageing. These two factors will determine both the capacity of the system to meet the needs for nursing services and also the level of demand for these services.

Education and support
While the focus of this Review has been on education, it is important to recognise that education must be responsive to the needs of the industry. There is a highly dependent relationship between these two industries and the organisations and people who constitute them.

Education and training provides new entrants to the health, community and aged care sectors, but these in turn need to support and develop new professionals so that nursing is an attractive option to those considering careers. All evidence suggests that it is vital that workplaces become more supportive and friendly. Nurses need to be encouraged and supported to remain in or return to the workforce in order to provide high levels of care, and to maintain the expertise needed for the development of new members of the profession.

Guiding themes
In approaching our task we have been guided by seven themes, which have formed the basis of our overall approach, the structure of the report and the detailed recommendations:

• The health care of Australians is a national issue to which nurses make a crucial contribution. A wide range of stakeholders is involved, including the different levels of government, the public and private sectors, and both education and health. Sometimes these stakeholders focus on their own special concerns and interests, and may not take full cognisance of the overall set of relationships in which nursing education and practice are embedded.

• Healthcare provision must be effective and efficient in the current climate of technological change, increasing pressure for services, cost constraints and growing demand on healthcare workers. However, these objectives have to be addressed in such a way that there is equitable access to education and training, and to healthcare treatment. The broad context in which these developments are occurring involves well-informed and demanding users.

• Nursing is a professional occupation and nurses are the largest professional group of workers in the healthcare system. However, the nursing workforce includes people with a very diverse range of skills, knowledge and experience. It is crucial that they are able to maintain their competence, develop it through lifelong learning, and maximise their contributions in the interests of both themselves and the overall healthcare system. Furthermore, the future workforce is likely to involve nurses working with other health professionals and care workers if the best outcomes are to be achieved.

• Nurse expertise is high in Australia. Future developments should build on current expertise and promote continuous improvement. A number of our recommendations address how these objectives might be achieved better in the future. This applies in nursing education and in practice—for example, by ensuring nurse educators and practitioners seek to, and are assisted to, update their competencies as technologies and scientific and social understandings develop.

• Nursing is part of a growing number of professions where thinking about the best way to prepare new professionals is changing. This thinking reflects new understandings of how learning occurs and its relationship to practice. As a practice discipline, nursing relies on hands-on activities based on theory and research. Consequently clinical...
education and support for transition to practice are essential components of nurses’ education and training. This integration of practice and theory must be an ongoing process throughout any nursing career or level of practice.

- Nursing is not representative of the diverse Australian population. For example, most nurses are women. Our vision is that the composition of the nursing workforce becomes more broadly representative of Australian society. Nursing needs to, and should be assisted to, encourage recruitment (and retention) through a wide range of pathways and support, including for new professionals, Aboriginal and Torres Strait Islander peoples, non-English speaking migrants, older people and men. We also argue that it is important to maximise the opportunities for nurses to advance to more senior positions in the nursing workforce (for example, from enrolled to registered nurse roles), and to move between different career options (for example, between nursing working in metropolitan and rural or remote areas, or between working as a practitioner, a manager or an educator).

- To achieve the strategic direction for nursing nationally, we believe that a cooperative partnership across governments and portfolios will be necessary. This partnership is one of many that will need to be formed to address the current difficulties effectively and achieve the most productive outcomes for patients and from education.

9.1.1 A vision for the future

Against this background we have made our recommendations within a broad framework that emphasises the valuable current contribution of Australia’s nurses and the possibilities for improvement. We hope that our recommendations, the developing consensus on the desirable directions of change, and the complementary activities of many other individuals and organisations will help nursing to respond positively to the current challenges. We see this positive response as based on the three main strategies:

- building a sustainable nursing workforce
- maximising health outcomes through high-quality education and training
- capacity building for individuals, health and education organisations, and the overall healthcare system.

To maximise the contribution of nurses to Australia, a range of ongoing partnerships need to be developed within a shared set of objectives for the future. Our report seeks to build those partnerships through this strategic vision and thus improve nursing education and practice.
Attachment A
Synthesis of submissions and comments to the Discussion Paper

Submissions to the terms of reference were invited at the beginning of the Review. A total of 159 submissions was received.

In December 2001 the National Review of Nursing Education released its Discussion Paper, which summarised the debate the Review Panel had heard up to that stage. The paper posed a number of questions and options for action and, to engage further debate, invited comments on a range of issues by 28 February 2002. We received 153 comments. While this summary takes as its main focus the responses to the Discussion Paper, much of the focus of the submissions is also captured.

The major themes that emerged from the comments related to the culture of nursing and to nursing education and training. Nursing workforce issues figured largely in responses, and repeatedly cut across comments on matters related to nursing education and training—often information and opinions on these could not be separated.

There were some issues on which a number of respondents made recommendations, including:

- a national representative nursing body
- the need to stimulate and strengthen nursing research in Australia
- a minimum qualification for unregulated healthcare workers to be Certificate III
- national consistency of nursing regulation
- a better system to ensure quality of clinical placements
- improved transition support programs for new graduates
- defined career pathways for nurses
- articulation of courses between all levels of nursing.

Respondents consistently stated that recruitment is not necessarily the main issue for nursing—instead, retention of the existing workforce and re-entry of registered (but not practising) nurses were the more critical factors. Respondents noted that many universities report that they fill their quota for nursing positions and have to turn students away. There was a general call for the Commonwealth to provide funding for additional university places for nursing students and for the resources required to underpin additional places.

On the subject of retention, a clear message from the comments was that the main cause for the current shortage of nurses in the workplace and for the inability to attract and retain nurses are the problems faced by nurses within the work environment. Respondents called for action from employers to address disparity of wages (particularly between aged care and acute care sectors), inflexible rostering, violence within the workplace, and the lack of support for professional development. Further, they noted that employers that do address conditions in the workplace succeed in maintaining their nursing workforce.

The nursing environment

Respondents acknowledged the nebulous nature of ‘nursing’. There was unanimous concern at the present poor perception of nursing as a career and strong recognition of the need for change. Although there was some debate, the predominant view was that the nursing profession must change from within—a change in culture cannot be imposed but rather must be encouraged and facilitated.
The nature of nursing and nursing work
Respondents expressed concern about the lack of definition for 'nursing' and what comprised 'nursing work'. A number of respondents raised questions about the inclusive or exclusive nature of the nursing profession, certain nursing work becoming more highly specialised, and how nursing work can best be performed while maintaining the patient as the central focus. These debates highlighted particular problems about the 'caring' essence of nursing and the varying scopes of practice for nurses. Many comments touched on the use of the unregulated workers and skilled technicians, which is expanded elsewhere in this report.

Scope of nursing practice
There were a number of comments stating that the roles between unregulated workers, enrolled nurses and registered nurses have become blurred. There was general recognition that the Australian Nursing Council Incorporated (ANC1) national competency standards reflect the characteristics of registered nurses and enrolled nurses and identify the knowledge, skills and attitudes required by enrolled nurses and registered nurses.

A number of comments called for clear delineation and definition of the scope of practice for unregulated care workers, enrolled nurses and registered nurses within a national framework. While many comments supported a national framework, a number also felt that State and Territory differences must be taken into account. It was pointed out that many good projects are currently under way in a number of States to review the scope of nursing practice, and this work should be considered and perhaps coordinated. A number of organisations referred to the Queensland Scope of Nursing Practice Decision Making Framework (Queensland Nursing Council, 2001) and thought that it could be used as the model nationally. Some respondents also recommended that a detailed analysis be undertaken to determine the current and future scope of nursing practice, and that critical discussion and debate is required with other health professionals to determine the responsibilities of nurses in diverse contexts and to articulate the interface between health professionals.

Technicians
There were a number of comments about the proposed introduction of technicians in a range of areas. Technicians are seen as a threat to nurses' scope of practice because they corner a highly specialised area of nursing work and come in 'sideways' through qualifications gained in the VET sector.

Working conditions
Respondents argued strongly that the key factors contributing to poor nursing culture were overwork and poor working conditions. The current working climate for nurses was identified as enormously stressful as consumer expectations rise, patient acuity increases, the number of experienced nurses dwindles, and the balance of work and home life becomes more important to nurses for their health and wellbeing. These and other factors mean that pressures are being brought to bear on nurses to the point that they choose to leave the profession. Ongoing industrial action and the current shortage of nurses willing to work in the healthcare system suggest that work conditions are fundamental to retention of the workforce. Respondents maintained that the present work conditions (particularly in aged care) did not recognise, value or support nurses in the work they do.

Aged care nursing
A large number of comments felt that aged care nursing will not be considered equally with acute care nursing as a nursing career option until there is equal pay and status. Over-regulation (and associated paperwork) was identified as one of the many factors that compound to act as a
disincentive for potential staff to seek qualifications and positions in aged care, and that caring for our ageing population in the future needs a total review in and of itself. A number of comments reflected the need for changes to the existing structure in which a few registered nurses are responsible for the activities of a larger number of unqualified and unregistered workers. This structure particularly reduces the attractiveness of working in aged care for registered nurses.

Development of career pathways
One of the major concerns identified was the lack of career pathways or positions that lead to strong career development for nurses. Moreover, the few options that do exist tend to take the nurse away from the bedside and into management or administrative roles. Respondents argued that the skills and knowledge base held by nurses is very broad due to the diversity of work settings and diversity of client needs. This skill base and level of flexibility shown by nurses is one of the reasons they are highly attractive to employers outside the nursing profession, and nurses are often enticed away from nursing because of strong career options in other fields. The creation of appropriate career pathways in diverse areas and specialties that allow nurses to build on their skills would help to retain nurses. Respondents repeatedly stated that career information must be readily available and marketed to both potential nurses and the existing workforce.

Nursing agencies
A number of organisations expressed concern at the use of nursing agencies and the cost to their health budget. There were comments that use of agency nursing over a number of years has led to the erosion of conditions of employment for registered nurses in the healthcare environment. Conversely, there were also comments that, in a competitive environment, service sectors that wish to attract and retain nursing staff will need to address professional satisfaction and opportunity, workplace satisfaction and remuneration, and accommodation of the preferred lifestyle of the applicant or current employee. Respondents felt that nurses will choose the area of employment that provides the best mix of these factors, and that employers will need to develop alternatives to dependence on agency nurses, and be willing to modify current work practices, especially staffing levels, workloads and employee support services.

Management and leadership
Comments consistently referred to a lack of visible nursing leadership in Australia, and that management/administration structures had slowly eroded any nursing positions of influence. Further, it was noted that excellence in nursing is often rewarded by promotion to a management/administration position away from the bedside. Also, in comments on leadership, two issues emerged on which respondents made specific recommendations.

A national representative nursing organisation
There was clear support for a position of Chief Nurse at the national level, although more focus was on the establishment of a national representative body. There was support for the establishment of some form of national nursing directorate or peak nursing body to provide leadership, national direction and influence, which should be adequately funded and supported by Commonwealth, State and Territory governments. It was suggested that this body could either be established and fostered through the creation of an umbrella body or facilitated through the forging of greater links between existing nursing organisations. A variety of names has been used for this group in the submissions and in the comments: National Nursing Directorate, Peak Nursing Group, Office of the Chief Nurse. Some respondents wanted this body to be positioned within the Commonwealth Government to give it an appropriate profile, while others felt that the group would best be outside government structure.
Marketing of the nursing profession

Marketing of the positive aspects of the nursing profession was seen as important as it was noted that most media attention is generally negative and focused on industrial matters. Respondents also referred to the unsupportive environment for nurses, from both within the profession and from other allied health areas, which often leaves nurses feeling disgruntled and unvalued. Also noted was the apparent lack of comprehensive careers information in schools about nursing. It was suggested that more work was needed to raise the profile of nursing to young people so they consider a nursing career as a real option.

Magnet hospitals

Magnet hospitals in the USA have proved highly successful—they promote leadership in nursing, and their work environment promotes the retention of nurses and a decrease in the use of agency staff, with fewer adverse events. The Magnet Hospitals Recognition Program is a model that takes nursing care to be the single most accurate predictor of health outcomes. Some respondents considered that a pilot of an adapted hospital recognition program would be an excellent first step in demonstrating how a healthcare organisation in Australian can achieve improvements in both nursing conditions and satisfaction and care delivery.

Nursing research development

Many respondents identified the need to stimulate and strengthen nursing research in Australia. Moreover, a strengthening of this research base and the consolidation of existing work were seen as critical for the maturing and defining of the profession. Respondents highlighted the fact that there is a great deal of excellent Australian nursing research and investigation occurring. However, this research is often not widely disseminated across State and Territory boundaries nor linked in a cohesive way. As such, many comments centred on the need to either formally put in place institutionalised nursing research to impose a coordinated approach, or (preferably) to focus efforts on creating linkages between existing research so work can be built on. There were suggestions of the establishment of a National Institute of Nursing Research, or that Commonwealth, States and Territories could fund a program to establish key centres for nursing research in each State.

Workforce planning—partnerships

Respondents generally agreed that building partnerships between all key stakeholders and working constructively together is the key to progress in workforce replanning. Workforce reform and planning should be undertaken nationally, with a whole-of-government approach, and should involve universities and TAFEs, representatives from the health sector (government, non-government and aged care sectors), students, health services and consumers. There were many comments along the lines that, while workforce planning should be the responsibility of the Commonwealth, the States and Territories should maintain a major role in determining the level and distribution of supply needs in their jurisdictions. There was support for strong partnerships between universities and State and Territory health departments to help address supply and demand, and for the development of Centres of Excellence—common learning or knowledge areas to feed into workforce planning.

Data

Many respondents commented that the lack of valid nursing data collection and analysis compromises the ability of both the education and service sector to adequately plan for enough education places to ensure supply for demand. There were suggestions that a national nursing workforce register be established to gather statistics, including the number of trained registered nurses and enrolled nurses, the number of nurses leaving the profession, the number graduating, and the number of specialist nurses not working in their area of speciality. Workforce planning is a key issue at the State and Territory level. It has to take into account local issues such as recruitment
numbers, student preferences, and resources for teaching and learning, including the availability of clinical placements. Respondents questioned if this could be done nationally.

Skill mix
Respondents also identified a need for further research to be undertaken to examine the relationship between healthcare needs, skill mix and patient outcomes to provide best practice guidelines for use in allocating staff.

Regulation and practice

National regulation/registration
There was differing support for national regulation. Many respondents called for a regulatory framework for all workers in nursing and personal care that provides parity with similarly qualified workers in allied sectors. They felt that consistency in nursing regulation across States and Territories could help to clarify identification of skills and training needs, and planning to meet such needs. The present inconsistency creates difficulties and confusion for individuals in a mobile workforce wanting to move across jurisdictions. However, some respondents also felt that consistency is more likely to be gained through national activities than through a national regulatory system.

Continuing education linked to registration
One area of debate centred on whether or not continuing education should be linked to registration requirements, on the basis that this was fundamental to quality patient care. Many comments recommended that all State and Territory nursing legislation have a requirement for continuing competency for practice to be assessed on a range of indicators, including continuing education, prior to re-registration. Continuing education was considered essential for the strengthening of the nursing profession, and many respondents felt this was a way of ensuring currency of skills and knowledge for practice, leading to improved quality of care outcomes for patients.

Unregulated health workers
Overwhelmingly, respondents supported the need for some form of regulation of unregulated care workers, with the most common suggestion being a minimum qualification of Certificate III. Unregulated workers are seen as being used by employers to contain costs in the aged care sector, and placing enormous stress on the registered nurses who supervise them. There were also calls for collaborative research into unregulated workers to identify best practice in relation to effectiveness as well as efficiency, taking into account a range of issues. There were suggestions that employers should have a Code of Practice, and should be required to ensure appropriate education and qualifications of workers involved in any level of nursing work.

Expanded roles for enrolled nurse
Many respondents referred to the under-utilisation of the enrolled nurse in the healthcare team due to lack of role clarification. Enrolled nurses are capable of working in a number of settings, not just aged care. The number of enrolled nurses who move on to the Bachelor of Nursing degree course indicates this group’s aspiration to increase knowledge and skills. It is also seen as an indication of their frustration with the limited career options available to them within enrolled nursing. There was support for expansion of the enrolled nurse role, with consistency on the scope of nursing practice for enrolled nurses nationally to enhance their standing, and for the amendment of drugs and poisons regulations in all jurisdictions to ensure consistency of the enrolled nurse role in medication administration.
Education and training

Many different aspects of education and training were identified in comments for all nursing levels, from workers not currently regulated who are involved in direct care work, enrolled and registered nurses, and those with specialist nursing qualifications. Some of the major themes were as follows.

Enrolled nurses

A number of respondents agreed that national consistency in enrolled nurse educational preparation is essential to achieve national competency standards, but recognised that there was considerable debate about the level of educational preparation. The revised ANCI competencies for enrolled nurses were seen to place enrolled nursing firmly as a part of the nursing profession and were seen to help differentiate the roles of the registered and enrolled nurse, and the enrolled nurse and the unregulated care worker. Respondents also identified a need for development of competencies for enrolled nurse specialisations, and for a clearly articulated pathway from enrolled nursing to transfer to university. The demand from enrolled nurses for enrolment in Bachelor of Nursing courses cannot be met. There should be an increase in funding specifically for articulated university places for enrolled nurses.

Registered nurse education

ANCI competencies

One issue that received considerable comment was the perceived lack of consistency in nursing standards and the differences in interpretation of the ANCI competencies. Also highlighted was lack of consistency in the accreditation of courses (which are currently accredited through the State and Territory Registration Boards). While there was universal opposition to a prescribed or common curriculum across Australia, there was strong support for the development of national guidelines. It was noted that the ANCI is currently developing a model for national standards development in association with the nurse regulatory authorities, and has planned a project to examine an approach, from a national perspective, to the accreditation of nursing courses.

Clinical placements/practice

There was universal agreement that the costs of clinical placements were prohibitive and that this was an area that needed immediate attention. A number of respondents felt that the universities and the profession should develop an agreed position about the need for clinical experience and the responsibilities of both parties in its provision. To allow clinical placements to be better planned, it was suggested that there be a State or National Summit to determine what clinical experiences the service sector could sustain and the needs of the universities in each area.

There was support for government funding to support partnerships between universities and health agencies to address problems of adequate funding for clinical placements and for the guaranteeing of clinical placements to meet student demand. Comments were also received about the quarantining of funding and nursing places—for as long as this does not occur, faculty resourcing decisions will have greater impact on supply than employer needs. Existing models of clinical placements and the manner in which clinical placements are managed received foremost attention in comments about nursing education. A number of existing models of managing clinical placements were presented to the Review.

There was some opposition to student nurses being employed as assistants in nursing (AINs) during their placements, and strong opposition to students being expected to work as AINs as part of their course as this does not allow students to practise commensurate with their level of education.

New graduate programs

A large number of respondents referred to the transition period between completion of the undergraduate degree and commencement of work as a registered nurse. Research shows that
registered nurses are confident and competent within six months of graduation. However, the transition process has been problematic and some respondents felt that this is because undergraduates do not receive enough clinical practice and this needed to be changed. Others stated that current undergraduate programs did provide students with enough clinical practice and we needed to examine the new graduate programs more closely.

Some respondents wanted to change the present undergraduate program—for instance, by extending it to four years with the final year composed of clinical practice, or by changing the undergraduate degree to a sandwich course model where students alternate between blocks of study at university and blocks of paid employment throughout the degree. Alternatively, some respondents supported some form of national consistency for new graduate programs, and for the development of an identified common core set of principles (not standards) for a new graduate program that could be used and recognised nationally. It was felt that new graduate programs should be developed jointly between health services and universities. The models of a number of new graduate programs were presented to the Review, and it was noted that there are good partnerships already in place between different universities and health service providers.

Specialist nursing education

There was support for specialist nurse education to remain in the higher education sector, and also support for the healthcare sector being the primary providers of speciality nursing education (with some input from universities). Some respondents thought that speciality courses that were responsive to the changing needs of the industry should run in partnership between hospitals and universities. Mental health, aged care and midwifery were identified as being areas of particular concern.

Many respondents felt there was a need to identify a group of nursing specialisation courses that should be uniformly available across Australia. Respondents were not consistent in identifying these courses and some suggested that some form of national nursing body could identify those speciality areas that should receive special funding.

It was suggested that a project could be put in place which aimed at achieving consensus within the profession on nomenclature and graduate outcomes. The project should involve key stakeholders and be adequately resourced to allow extensive research, consultation and dissemination.

Respondents generally supported the retention of the current three-year model of undergraduate education rather than the introduction of changes to allow substantial experience in a specialist area during the undergraduate degree. If any felt that the undergraduate degree prepared a graduate in the principles and competencies required in nursing rather than specifics (apart from clinical skills) and that specialist education should be postgraduate, as is the case with medicine. Respondents were concerned that changing the current model may lead to role confusion between ‘generalist’ and ‘specialist’ nurses, articulation with existing postgraduate speciality courses, and the danger in specialising too early before a solid foundation has been developed.

Respondents felt that funding for specialist education in particular areas of need should be provided by Commonwealth, State and Territory governments if and when necessary. Funding should be provided for courses in areas experiencing shortages as well as those that most benefit the health of the community.

Professional development and continuing nurse education

The comments received showed universal support for nurses to undertake professional development activities and continuing education. These activities are seen to be an integral part of a profession. If nurses are to further their professional standing and facilitate improved quality of care for their patients, professional development and continuing education must be strongly promoted. Although there was some debate, the general view was that professional development was the responsibility of both the individual and the profession. It was noted, however, that employers also have a responsibility to ensure the currency of skills and knowledge of their employees. The following key issues were raised.
Strong linkages between education and practice
There was strong support for the development of more structured and collaborative links between the education sector and the health sector for professional development courses. Respondents noted that there are some excellent models of collaboration and partnership but there is still a gap between these two areas that is hindering the development of the profession in a cohesive manner, and there needs to be collaboration in curriculum and program development to more closely align to workplace needs. Respondents supported the establishment and further development of Clinical Schools of Nursing, and encouraged a shift in thinking in clinical areas to develop research and evidence-based practice.

Credentialling
There were mixed comments on credentialing. Some respondents supported a national credentialing system to be established, usually for specialty practice or for advanced practitioners. Much of the support for credentialing focused on its ability to ensure consistent levels of current skills and knowledge that are required for practice. It was noted that a system of credentialing is currently in place for midwifery. There were also comments that there was a lack of evidence on the supposed benefits of credentialing (such as improved patient outcomes, better quality of care, giving nurses a sense of personal achievement), and that nurses were already adequately regulated to ensure consistency of skills and to address quality and safety issues.

Funding
Respondents argued strongly that adequate funding must be provided at all levels to encourage and support the ongoing professional development and continuing education of nurses. Much of the comment was directed at a national level in terms of the Commonwealth providing adequate funding to the States and Territories, or providing tax incentives to individuals to facilitate a greater uptake of activities for lifelong learning. It was also felt that individual organisations must shoulder some responsibility and actively facilitate the development of their staff through incentives or funding support.

Workplace support for professional development
A number of respondents identified the need for employers to provide support measures to encourage and facilitate the professional development of their employees. These could include professional development plans for individual employees, career paths identified for all levels of nursing, mentoring programs or structured preceptorship programs available to all staff, establishment of clinical coordinators/preceptor positions to aid workplace transition and workplace development, and transition programs that allow new staff to be supernumerary for a designated period. Further, paid study leave should be available to all staff, and professional development/education units and clinical nurse educators should be established (or maintained where they are already in place).

HECS fees
There were a number of comments about student fees, including suggestions that HECS fees be removed for undergraduate and/or postgraduate nursing courses, and that additional undergraduate and postgraduate rural nursing scholarships be funded (to at least the same level as rural medical scholarships). Some respondents thought that specialist education (postgraduate courses) should be HECS liable, that scholarships should be available from employers or governments, and that nursing courses for specialist areas with no identified shortages should qualify for funding through the Postgraduate Education Loan Scheme (PELS).
Attachment B
Senate Community Affairs References Committee—Inquiry into Nursing

The Report on the Inquiry into Nursing

The Senate initially referred the following matters to the Senate Community Affairs References Committee for inquiry and report by 25 October 2001. This reporting date was not able to be met because the Federal Election was called towards the end of 2001.

The inquiry was re-referred by the Senate on 14 February 2002 and the Committee was required to report by 27 June 2002. The report, The Patient Profession: A time for action was subsequently presented to the Senate on that date.

It is rare for two major inquiries on the same issue to be called simultaneously. We consider the large number of written submissions made to both inquiries by individuals, nursing groups and organisations, and the time taken by so many in the profession to meet with the Committee or our Review Panel reflects the enormous concern for the future of nursing in this country. We support a number of the desired outcomes for nursing presented in the Senate report, although our suggested course of action for the future and recommendations may differ on some issues. However, we argue the findings reported by both inquiries make a powerful statement on the crucial role nursing must play in the future health care of all Australians.

The Senate Committee report sets out the arguments presented to the Committee members and endorses a large number of recommendations around those issues. In our report, although we do address many similar issues (reflecting similarities in some of the terms of reference for both this Review and the Senate Committee Inquiry), we have attempted to put together structures under which these different concerns can be strategically addressed and which set out the steps forward. As is apparent from our recommendations, we also agree that there is a need for more ‘action’ around nursing—but we also acknowledge the great deal already being achieved across all areas and jurisdictions. What is needed is for future action to be deliberated and planned strategically by all involved in nursing: governments, employers and educators. As concluded by the Government members of the Senate in the Government Members Minority Report, this ‘needs the cooperation and goodwill of all stakeholders’ (Senate Community Affairs References Committee 2002, p. 203).

Government Members Minority Report

The Government Members Minority Report sets out the background to the calling of the National Review of Nursing Education and the Senate Inquiry into Nursing. The report points out the many groups that have responsibility for nurses and nursing, and outlines a number of important initiatives introduced by the Commonwealth Government in an effort to address nursing shortages. The Government Senators recommended that the recommendations of this Review should be considered before any further action was planned or taken.
Terms of reference

The complete terms of the reference for the inquiry are:

(a) the shortage of nurses in Australia and the impact that this is having on the delivery of health and aged care services

(b) opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses.

That the Committee specifically make recommendations on:

(i) nurse education and training to meet future labour force needs

(ii) the interface between universities and the health system

(iii) strategies to retain nurses in the workforce and to attract nurses back into the profession including the aged care sector and regional areas

(iv) options to make a nursing career more family friendly

(v) strategies to improve occupational health and safety.
Attachment 1.1
Expenditure on health services

Recurrent expenditure on health services in Australia is described by using two broad categories of health services: institutional services and non-institutional services. This follows the format suggested by the World Health Organization.

Areas of expenditure within the institutional health services group are:
• hospitals
• high-care residential aged care (formerly nursing homes)
• ambulance (patient transport) services
• other institutional health services.

Non-institutional services include:
• ambulatory health services, such as those provided by doctors, dentists and other health professionals
• community health services and public health services
• health goods (pharmaceuticals, aids and appliances) provided to patients in the community
• health-related expenditures, such as expenditure on health administration and research.

Hospitals and medical services account for more than half of the expenditure listed as health expenditure. In 1998–1999 hospitals were estimated to have accounted for 38.0 per cent of total recurrent expenditure on health services, and medical services 19.0 per cent (AIHW 2001b).

Expenditure on public hospitals and private hospitals grew, in real terms, between 1989–1990 and 1999–2000. Annual growth in expenditure on public hospitals averaged 2.8 per cent per year over the period, while expenditure on private hospitals grew at an average of 6.9 per cent. Expenditure on public psychiatric hospitals, on the other hand, experienced real decreases in most years. Over the same period, the average annual decrease in expenditure on public psychiatric hospitals was 4.5 per cent. Expenditures classified as medical services include medical services provided to private patients in public and private hospitals (AIHW 2001b, p. 25).

During 1998–99 almost two-thirds of all expenditure on private hospitals was paid through private health insurance funds. Of this, 51.0 per cent was the net benefits paid by private health insurance funds and 12.7 per cent was indirectly financed by the Commonwealth Government through its subsidies to private health insurance policyholders under the Private Health Insurance Incentives Act 1997. A combination of out-of-pocket expenditure by individuals, payments by the Department of Veterans’ Affairs and other non-government sources funded the remaining 36.3 per cent (AIHW 2001b, p. 31).

4 Within these two categories, however, there is substantial overlap. For example, public hospitals spent $2 076 million on salaried medical officers and visiting medical officers during 1998–99 (AIHW 2000b). While these are payments in respect of staff that provide ‘medical-type’ services, they are included in the gross operating costs of the public hospitals and are counted as expenditure on public hospitals. Also, some other expenditures that make up the estimates of expenditure on hospitals (for example, salaries of technical staff involved in providing diagnostic services) relate to the provision of ‘medical-type’ services provided to public patients in hospitals. In respect of medical services provided in hospitals, some of the expenditure that is recorded as expenditure on hospitals relates to services that could also fit other expenditure categories. Other such examples are community and public health activities that are based within public hospitals. The associated expenditure is captured as expenditure on public hospitals, not as community and public health. Similarly, expenditure on medications provided to patients in hospitals is counted as expenditure on hospitals. Expenditure on drug supplies in public hospitals during 1998–99 was $0.7 billion (AIHW 2000b). Expenditure on drugs, medical and surgical supplies in private hospitals was $0.6 billion (ABS 2000b).

5 This category does not include psychiatric hospitals.
Total recurrent expenditure on high-care residential aged care in 1998–99 was $4066 million. Of this, the Commonwealth Government paid $3011 million and the non-government sector paid $111 million (AIHW 2001b, p. 31).

Table A1.1.1 Proportions of recurrent Australian health services expenditure (in per cent), current prices ($ million), by areas of expenditure, 1989–1990 to 1998–1999

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total institutional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>40.6 (10 882)</td>
<td>38.6 (12 670)</td>
<td>37.5 (14 782)</td>
<td>38.0 (18 031)</td>
</tr>
<tr>
<td>Government (non-psychiatric)</td>
<td>32.3 (8 658)</td>
<td>29.8 (9 775)</td>
<td>28.3 (11 147)</td>
<td>28.8 (13 675)</td>
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<tr>
<td>Private hospitals</td>
<td>6.3 (1 701)</td>
<td>7.3 (2 384)</td>
<td>8.1 (3 183)</td>
<td>8.3 (3 959)</td>
</tr>
<tr>
<td>High-care residential aged care</td>
<td>8.3 (2 230)</td>
<td>8.1 (2 648)</td>
<td>7.5 (2 954)</td>
<td>8.6 (4 066)</td>
</tr>
<tr>
<td>Total non-institutional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical services</td>
<td>18.4 (4 945)</td>
<td>19.6 (6 422)</td>
<td>20.0 (7 872)</td>
<td>19.0 (9 001)</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>3.7 (1 000)</td>
<td>3.7 (1 207)</td>
<td>3.4 (1 350)</td>
<td>3.9 (1 860)</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>9.3 (2 490)</td>
<td>10.4 (3 432)</td>
<td>11.8 (4 657)</td>
<td>12.3 (5 819)</td>
</tr>
<tr>
<td>Other non-institutional services</td>
<td>14.4 (3 877)</td>
<td>14.4 (4 723)</td>
<td>14.5 (5 695)</td>
<td>14.0 (6 652)</td>
</tr>
<tr>
<td>Community/ public health</td>
<td>5.6 (1 510)</td>
<td>4.9 (1 611)</td>
<td>5.1 (2 010)</td>
<td>5.9 (2 815)</td>
</tr>
<tr>
<td>Dental services</td>
<td>5.1 (1 374)</td>
<td>5.9 (1 944)</td>
<td>6.0 (2 373)</td>
<td>5.4 (2 566)</td>
</tr>
<tr>
<td>Health administration</td>
<td>3.7 (994)</td>
<td>3.6 (1 168)</td>
<td>3.3 (1 311)</td>
<td>2.7 (1 271)</td>
</tr>
<tr>
<td>Research</td>
<td>1.5 (400)</td>
<td>1.5 (477)</td>
<td>1.6 (638)</td>
<td>1.5 (725)</td>
</tr>
</tbody>
</table>

Note: Numbers in brackets represent expenditure at current prices in millions of dollars referenced to 1998–99. Not all areas of expenditure are detailed here. Adapted from tables in AIHW (2001b)
Attachment 2.1
International inquiries and responses to nursing

Ireland

The 1998 report of the Commission on Nursing, A Blueprint for the Future, contained a wide range of recommendations for the development of nursing and midwifery as a key profession within the health service in Ireland. The Department of Health and Children agreed to begin implementing the core recommendations during 2000 and 2001 under a Priority Action Plan. As part of the process, a Monitoring Committee was established in February 2000.

Some of the recommendations that have been implemented to date and the mechanisms put in place to assist their implementation are outlined below (Department of Health and Children 2002).

In November 2001 the Minister for Health and Children launched the new four-year undergraduate pre-registration nursing degree program, commencing in 2002. The Minister allocated substantial additional capital and revenue funding to aid the development of the new undergraduate program. Purpose-built facilities to accommodate nursing degree students are being built at 13 higher education institutions throughout the country as part of the program. A total of 1640 places nationally will be available annually on the degree program.

The National Council for the Professional Development of Nursing and Midwifery (the National Council) was established in November 1999 to implement recommendations on career pathways and initiatives in continuing education. To date the National Council has:

- developed immediate and future career pathways guidelines for confirming nurses and midwives into clinical specialist/clinical midwife posts, in order to provide a coherent approach to the progression of specialisation and the development of a clinical career pathway for nursing and midwifery
- developed the definition, core concepts and a framework for the development of advanced nurse practitioner and advanced midwife practitioner posts to create a clinical career pathway for nurses and midwives
- provided funding to regional nursing and midwifery planning and development units to support additional developments in continuing education
- established a Working Group in 2001 to examine the effective use of the professional skills of nurses and midwives, and the development of appropriate systems for determining staffing levels. The Working Group recommended that a grade of Health Care Assistant/Maternity Health Care Assistant be introduced as a member of the healthcare team. A Review Group on Health Service Care Staff, informed by the work of the Working Group, was established to examine opportunities for increased use of care assistants and other non-nursing staff. A pilot program for the formal training of healthcare assistants has been running on a national basis for almost six months.

A National Strategy for Nursing and Midwifery in the Community was developed to address issues around nursing research. The strategy will play a key role in establishing processes to ensure the development of a research-based culture aimed at ensuring continuous improvement in the delivery of nursing/midwifery care. The strategy document is due to be published in August or September 2002.
United Kingdom

There has been a range of initiatives in the United Kingdom with implications for nursing, including nursing regulations and the funding of nurses and nursing education. In 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) was set up to replace the existing regulatory structure. Its core functions were to maintain a register of United Kingdom nurses, midwives and health visitors, provide guidance to registrants, and handle professional misconduct complaints. At the same time, National Boards were created for each of the United Kingdom countries. Their main functions were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses.

This structure survived with minor modifications up to April 2002, when the Nursing and Midwifery Council replaced the UKCC and National Boards. Parliament set up the Nursing and Midwifery Council to ensure nurses, midwives and health visitors provide high standards of care to their patients and clients. The English National Board was abolished and its quality assurance role taken over the by Nursing and Midwifery Council. The National Boards for Scotland, Wales and Northern Ireland were also abolished and new bodies are being established in these countries to oversee non-regulatory aspects of education. The Council has contracted with these bodies to deliver its educational quality assurance model in the three countries.

To achieve its aims, the Council will:

- maintain a register of qualified nurses, midwives and health visitors
- set standards for education, practice and conduct
- provide advice for nurses, midwives and health visitors
- consider all allegations of misconduct or unfitness to practise due to ill health.

All trained nurses, midwives and health visitors must be registered with the Council in order to practise in the United Kingdom. The register of nurses is at the centre of the role of the Council in public protection. The register currently holds around one million names, with around 640,000 of those nurses holding current registration.

Registration must be renewed every three years and in order to maintain registration, all nurses, midwives and health visitors must comply with Post Registration Education and Practice requirements, which include a minimum of five days or equivalent of learning activity every three years and maintaining evidence of professional development.

National Health Service Plan

In 2000 the National Health Service (NHS) Plan in the United Kingdom represented the replacement of the previous top-down centralised NHS towards a devolved health service. The Government released a new document, Delivering The NHS Plan—next steps on investment, next steps on reform (Secretary of State for Health 2002), in April 2002. In this document the Government set out the next steps for reform following the announcement of an average 7.5 per cent real growth in the NHS in England over each of the next five years. At the same time the Government agreed with the conclusions of the Wanless Review report, Securing our Future Health: Taking a Long-Term View (Wanless 2002), which recommended extra investment in the NHS and social care in order to achieve the reform and modernisation promised in the NHS Plan.

The total NHS budget in the United Kingdom will climb from £65.4 billion in 2002–2003 to £105.6 billion in 2007–2008—a doubling of the annual budget since 1997. The additional money will be used to recruit and train thousands of extra staff and treat more patients, as well as to introduce new reforms including a financial system of payment by results and measures to increase patient choice.
The British Government has made a sizeable financial commitment to the nursing workforce: by 2008 the additional funds will provide for 35,000 more nurses, midwives and health visitors. The initiative will result in an additional 8000 nurses per annum completing their education by 2008—a 60 per cent increase from 2000–2001. Other improvements for staff include:

- the star rating system, including an assessment of how well NHS organisations treat and involve their staff
- extra pay for staff who make the biggest contribution to the NHS
- more lifelong learning opportunities.

Student nurses in the United Kingdom undertake either a pre-registration diploma or a degree at university. Diploma students can transfer to degree courses, or complete the necessary studies to gain their nursing degree at a later stage. Financial support is provided to students by means of a bursary system. Nursing and midwifery students on diploma courses receive a non-means-tested bursary between £5305 and £6323. Nursing students in degree programs, as with all degree students, receive a means-tested bursary of between £1717 and £2578, supplemented by a reduced-rate repayable student loan. The NHS also meets the student liability for tuition fee contribution. Older students, single parents and those with dependants are liable for additional allowances and students can claim the travel costs they incur while on clinical placements. The salary rates for healthcare workers have also been reviewed.

New Zealand

In March 2000, the Nursing Council of New Zealand commissioned a review of undergraduate nursing education. In May 2001 KPMG, a business advisory firm, delivered the Final Report of the Strategic Review of Undergraduate Nursing Education to the Council (KPMG 2001). The report marked the end of an extensive strategic consultation process on nursing education in New Zealand.

The New Zealand review considered the changing context of nursing and the attributes required of nurses in the future. Consistent with the objectives of the review, the report focused on the preparation of registered nurses, but acknowledged the relationship of the newly registered nurse to the preparation of the nurse practitioner at one end of the clinical continuum, and the team support assistant or ‘second level carer’ at the other. The report noted that the need for recognition of this clinical continuum could not be overemphasised, as the risk of a fragmented approach would do little to support integrated workforce development strategies for the future.

In July 2001, the Nursing Council reported that it had accepted the recommendations (Nursing Council of New Zealand 2001). Work had already begun prioritising and implementing the recommendations, consulting with the profession and developing realistic timeframes for the implementation of the recommendations. The Council noted that some recommendations required action from the relevant Ministers of the Crown and their agencies. The Nursing Council had adopted a policy to approach the appropriate agencies to discuss the recommendations and their implications. A communication strategy had been developed to ensure education and service providers would be well informed before any recommendations are implemented.

One of the recommendations of the report was that the current payment arrangements for clinical education be reviewed. In March 2002, the Nursing Council made a Submission to the Minister of Health and Associate Minister of Education (Tertiary Education) on the funding of the clinical training component of pre-entry comprehensive nursing education, where education providers are funded to purchase clinical training from service providers (Nursing Council of New Zealand 2002a). The submission recommended that the joint Ministers should note the importance of access to clinical training in the preparation of comprehensive nurses. The major weakness in the current system was that the cost of clinical training services was greater than the funding allocated to education providers to purchase them.
The New Zealand Review also identified three other areas for consideration.

Workforce issues
The report considered the impact of workforce issues on the recruitment and retention of nurses, and the need to promote nursing as a worthwhile career. It recommended that a nationally funded and coordinated recruitment program be targeted at the recruitment of specific groups.

Transition year
The report recognised the first year of practice/transition year as most important, as it is often the time when nurses leave the profession or make decisions about the areas in which they may wish to specialise. It is a time when development and support of the new graduate is crucial, and the report made a number of recommendations in this regard.

Collaborative approaches to nursing education
The report noted the lack of a process where education, service, professional and industrial groups can work together to ensure that preparation of nurses is part of a planned and strategic solution for future requirements, and that this needed to be addressed. In relation to clinical experience during the degree program, the report recommended that constructive partnerships between education and service providers must be established, and recommended that the Nursing Council establish guidelines with both education and service providers to ensure the quality of clinical practice delivered. Collaborative relationships between education providers were also recommended to allow large and small providers access to combined expertise, and to ensure cost-effective quality, teaching and learning models were developed for undergraduate nursing programs.

Canada
In October 2000, as part of a Canada-wide initiative by the federal, provincial and territorial ministers of health, the Advisory Committee on Health Human Resources Working Group on Nursing Resources released The Nursing Strategy for Canada (Advisory Committee on Health Human Resources 2000). This document followed an extensive consultation and submission process involving key stakeholder groups throughout Canada. Some of the issues highlighted by stakeholders, and reflected in the recommended strategies in The Nursing Strategy for Canada, included the need for:

- a unifying and multi-stakeholder advisory committee to address the most pressing nursing workforce issues and to provide advice and support for provinces and territories
- increased and improved nurse workforce planning, and support for the federal government to take a lead role in the development of better health human resource data to establish improved future projections for nursing supply and demand
- increased nursing school capacity, supported by adequate clinical placements
- attention to the educational needs of the existing workforce, particularly for continuing education, to increase competencies and for specialty training
- determination of the optimal nurse-mix and use of non-nursing personnel aimed at improving both the quality of work life for nurses and patient outcomes.

The document proposes 11 strategies for change, organised according to the following key issues:

- unified action
- improved data, research and human resource planning
appropriate education
improved deployment and retention strategies.

Strategy 1 of The Nursing Strategy for Canada recommended the establishment of a coordinating body, the Canadian Nursing Advisory Committee, to provide informed advice on priority issues to the ministers of health through the Advisory Committee on Health Human Resources.

In progressing the Nursing Strategy, the Advisory Committee on Health Human Resources has now appointed 16 members to the newly established Canadian Nursing Advisory Committee. The Committee is to give priority to providing advice on improving the quality of work life for nurses. In its advice it must reflect an integrated stakeholder perspective and promote effective linkages with relevant groups, committees and bodies. Membership of the group comprises government representatives, nursing groups, nursing educators, unions and employers.

World Health Organization

The 49th World Health Assembly urged Member States to strengthen nursing and midwifery. To this end it established the Global Advisory Group on Nursing and Midwifery. The recommendations of the sixth meeting of this group in November 2000 cover the following areas with reference to nursing and midwifery:

- World Health Organization (WHO) global agenda and policy formulation
- underlying analytic and evidence base
- capacity building and support for sustainable change
- ongoing advocacy and assurance.

In Nurses and Midwives for Health: WHO European Strategy for Nursing and Midwifery Education (Section 1-8 2001b, Section 9 2001c), WHO provides a set of guidelines for curricula development including prototype curricula in Section 1-8: Guidelines for Member States on the implementation strategy. In Section 9 they provide a Prospective Analysis Methodology Questionnaire for use in the Member States for assessing their baseline position and their progress against the fundamental principles for initial education. These principles are provided separately for nursing and midwifery, but to avoid redundancy they have been combined in the lists following.

WHO also outlines the fundamental guiding principles of continuing education for nurses and midwives in the Nurses and Midwives: Fitness for Purpose. A WHO European Strategy for Continuing Education for Nurses and Midwives (WHO 2001a), though these are not presented here.

Fundamental principles of the initial educational programmes for nursing and midwifery

(These principles are premised on one level of regulated nurse)

- Nursing and midwifery must be an integral part of the essential legislative and regulatory framework for the health care professions within each Member State.
- Nursing and midwifery education practice must be underpinned by values focusing on the promotion and maintenance of health in individuals, families and communities and on individuals and holistic care of those who are ill. It must promote non-judgmental care that is sensitive to the social, cultural, economic and political context of the country.
- Nursing education and practice must take into account the healthcare needs of the population of the country and be conducted to agreed standards for quality of care.
- Nursing and midwifery education must have the individual, be it the patient or the healthy person, as its main focus, but must also take into account the significance of the contexts within this focus.
which those individuals live and work, including their families, partners, social groups and communities.

- A proportion of nursing and midwifery education must be interdisciplinary and multi-professional, in order to facilitate effective teamwork and contribute to cost-effective delivery of care.
- Admission to nursing and midwifery education must follow successful completion of secondary school education, with qualifications equivalent to those required by the individual Member States for university entrance. Alternatively, entry may be based on formal accreditation of prior learning and/or relevant experience, provided this is a normal route of entry to the university concerned and is acceptable to the nursing and midwifery statutory body, where one exists.
- The length of the programme must be sufficient to achieve the specified competencies and must not be less than three years.
- Students must not be required to be employees during their education and must enjoy a status equivalent to that of other university students. This must apply throughout the theory and practice components of the course.
- Successful completion of a nursing or midwifery programme must lead to professional qualification as a nurse or midwife.
- Qualification as a midwife may be achieved either via a programme based on prior qualification as a nurse or via a direct-entry programme.
- The academic level of the professional qualification as a nurse or as a midwife must be that of a university degree in nursing or midwifery.
- There must be one level of qualified nurses and one level of qualified midwife. This nurse or midwife, as is the case with other health professionals, may be supported by a trained healthcare assistant.
- The curriculum must be research-, evidence- and competency-based.
- The specified competencies must include the ability to practice in hospital and community settings and as a member of the multi-professional health care team.
- The relevant Council Directives for nursing and midwifery must serve as a minimum.
- Initial preparation and qualification must form the basis of continuing professional development and education, which is essential for maintaining and further developing competencies for existing practice, for specialisation and for the flexibility required for nurses and midwives to continue to contribute to changes and advances in health, nursing and midwifery care.
- The university, its school or department of nursing and/or midwifery, and the practice placement area in the hospitals or community settings must be formally accredited and have in place systems of quality improvement/control.
- The nursing and midwifery programmes must also be formally accredited, regularly reviewed and have valid systems of evaluation and quality improvements/control in place at the local and national levels.
- All nursing and midwifery programmes should have credits allocated to the learning that take place in both the educational institution and the practice placement settings.
- The director or head of the nursing school or department must be a qualified nurse, and director or head of the midwifery school or department must be a qualified midwife.
- The teaching of nursing, in both theory and practice, must be carried out by a qualified nurse and the teaching of midwifery, in both theory and practice, must be carried out by a qualified midwife.
- Teachers of nursing and midwifery must:
  - hold a degree at an academic level equivalent to the requirements for university teachers in the country in question
- hold a teaching qualification in order to apply appropriately the full range of research-based teaching, learning and assessment strategies within the theory and clinical components of the curriculum
- hold the qualification to which the programme leads
- have a minimum of two years of relevant practical experience
- teach within the area of specialist nursing and/or midwifery practice in which they have expertise
- maintain their clinical competence, and
- be responsible for the clinical supervision of students on practice placement within their areas of specialisation (this responsibility must be shared with the student’s clinical mentor).

• Clinical nurses and midwives who teach, act as mentors and support students in their practice placements must:
  - be experts in their field of practice
  - receive appropriate preparation for their roles as teachers, mentors and providers of support, and
  - maintain their clinical competence.

• Student nurses and student midwives must receive clinical supervision while in clinical placements, whether in hospital or community settings. The level and amount of supervision should correspond to the stage of their education.

• Teachers from disciplines that contribute to nursing or midwifery education, such as health and medical sciences, including pharmacology and epidemiology, behavioural and biological sciences, law and ethics, must be experts in their own subjects and hold a degree equivalent to the requirements for university teachers within the country in question.

• University schools and departments of nursing and midwifery must have, or have adequate shared access to, appropriate human and physical resources, including equipment, clinical skills laboratories and libraries, to enable the delivery of programmes at both the undergraduate and postgraduate levels.
Attachment 2.2
Job growth and turnover in nursing and related occupations

This section draws heavily on the commissioned research for this Review which was reported in Job Growth and Replacement Needs in Nursing Occupations (Shah & Burke 2001).

Between 1987 and 2001 employment of nursing workers grew at an average annual rate of 0.8 per cent, to total 249,000 in 2001. However not all States and Territories recorded growth. Employment declined in South Australia and Tasmania. In Queensland the annual growth rate was 2.7 per cent. In comparison, the employment growth across whole economy was 1.6 per cent.

The differential growth rates of the nursing workforce across States and Territories reflect the differential population changes as well as staffing policies across these jurisdictions. One way to control for population changes is to consider the number of nursing workers per 100,000 population. In Australia the number of nursing workers per 100,000 population peaked at about 1400 in the second half of the 1980s. The ratio has been steadily declined since then and currently stands at about 1300, which is just below the level in 1987. The ratios varied widely across States and Territories in the mid-1980s, but have been converging ever since to the ratios for New South Wales, Queensland and Western Australia which have remained relatively stable.

Table A2.2.1 Employment growth of nursing workers by State and Territory, 1987–2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Employment 2001 (‘000)</th>
<th>Change 1987–2001 (%)</th>
<th>Annual growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>79.3</td>
<td>20.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Victoria</td>
<td>64.8</td>
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<tr>
<td>Queensland</td>
<td>46.3</td>
<td>33.3</td>
<td>2.7</td>
</tr>
<tr>
<td>South Australia</td>
<td>21.3</td>
<td>-9.1</td>
<td>-1.1</td>
</tr>
<tr>
<td>Western Australia</td>
<td>24.4</td>
<td>21.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Tasmania</td>
<td>6.4</td>
<td>-16.7</td>
<td>-1.1</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2.4</td>
<td>48.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>3.6</td>
<td>12.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Australia</td>
<td>248.4</td>
<td>17.5</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Note: The annual rates were estimated by fitting a log linear model to the annual employment data. Only estimates for Victoria and the Australian Capital Territory are not significant at less than 10 per cent level.

Source: Table 2, Shah & Burke, 2001.

Nursing professionals

The largest single nursing professional occupation is that of the registered nurses with employment of 163,500 in 2001. The employment changes of this group between 1987 and 2001 are quite interesting in light of the current reports of shortages. The occupation saw healthy growth between 1987 and the recession of 1991–92. Employment remained virtually unchanged from then until just recently. The last year has seen very sharp increase in employment.

Registered midwives is the second significant professional nursing occupation. According to Shah and Burke (2001), their employment increased gradually between 1987 and 1999, and in the two years to 2001 there was very substantial growth in their employment. Current employment level in the occupation is just over 10,000.
Enrolled nurses

The employment of enrolled nurses reached a peak of 35,600 in 1989. Since then it has gradually declined to 22,500 in 2001, with only a partial reversal in the downward trend between 1995 and 1998. Table A2.2.2 below compares enrolled nurse employment and growth rates by State and Territory across the period 1987-2001. While most States and Territories recorded growth between 1987 and 2001, sharp falls were recorded in the two largest States of New South Wales and Victoria, as well as in Tasmania.

Table A2.2.2 Employment of enrolled nurses by State and Territory, 1987-2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Employment level 2001 ('000)</th>
<th>Total growth 1987-2001 (%)</th>
<th>Average annual growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>5.2</td>
<td>-30.4</td>
<td>-1.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>2.7</td>
<td>-67.6</td>
<td>-5.3</td>
</tr>
<tr>
<td>Queensland</td>
<td>5.6</td>
<td>27.3</td>
<td>2.3</td>
</tr>
<tr>
<td>South Australia</td>
<td>4.7</td>
<td>22.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Western Australia</td>
<td>3.5</td>
<td>3.5</td>
<td>-0.2</td>
</tr>
<tr>
<td>Tasmania</td>
<td>0.4</td>
<td>-52.1</td>
<td>-10.0</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>0.2</td>
<td>211.1</td>
<td>-0.8</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>0.2</td>
<td>28.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Australia</td>
<td>22.5</td>
<td>-20.6</td>
<td>-1.2</td>
</tr>
</tbody>
</table>

Note: The average annual rate was estimated by fitting a log linear model to the annual employment data. Only estimates for Victoria, Queensland and Tasmania are significant at less than 10 per cent level.
Source: Table 6, Shah & Burke 2001.

Personal carers and nursing assistants

The employment pattern of personal carers and nursing assistants shows a period of growth from 1987 until the 1991-92 recession. It was then followed by another period of growth after the recession, but a sharp decline since 1997. By 2001 the employment level in this occupation at 39,300 which was below its level in 1987. However employment increased in New South Wales, Queensland and the two Territories. Table A2.2.3 compares the reported employment levels and growth rates for personal carers and nursing assistants.

Table A2.2.3 Change in employment of personal carers and nursing assistants by State and Territory, 1987-2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Employment level 2001 ('000)</th>
<th>Total growth 1987-2001 (%)</th>
<th>Average annual growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>13.4</td>
<td>20.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Victoria</td>
<td>7.4</td>
<td>-8.0</td>
<td>-2.3</td>
</tr>
<tr>
<td>Queensland</td>
<td>9.9</td>
<td>47.5</td>
<td>3.9</td>
</tr>
<tr>
<td>South Australia</td>
<td>2.4</td>
<td>-60.9</td>
<td>-5.4</td>
</tr>
<tr>
<td>Western Australia</td>
<td>4.6</td>
<td>-18.7</td>
<td>-1.7</td>
</tr>
<tr>
<td>Tasmania</td>
<td>0.9</td>
<td>-41.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>0.3</td>
<td>0.8</td>
<td>-2.2</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>0.4</td>
<td>2.9</td>
<td>-0.1</td>
</tr>
<tr>
<td>Australia</td>
<td>39.3</td>
<td>-1.7</td>
<td>-0.2</td>
</tr>
</tbody>
</table>

Note: The average annual rate was estimated by fitting a log linear model to the annual employment data. Only estimates for Victoria, Queensland South Australia and Western Australia are significant at less than 10 per cent level.
Source: Table 7, Shah & Burke 2001.
Aged or disabled person carers

In contrast to enrolled nurses and personal care and nursing assistants, there has been very strong growth in the employment of aged or disabled person carers. The size of the occupation in 2001 was four times its size in 1987, and has grown at an average annual rate of 10 per cent during this period (refer Table A2.2.4). There were 71,000 aged or disabled person carers in employment in 2001, 85 per cent of whom were female. The growth in this occupation does not appear to have been affected by the 1992–92 recession.

Table A2.2.4 Changes in employment of aged or disabled person carers by State and Territory, 1987–2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Employment Level 2001 ('000)</th>
<th>Change 1987 to 2001 (%)</th>
<th>Annual growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>14.9</td>
<td>291</td>
<td>8.4</td>
</tr>
<tr>
<td>Victoria</td>
<td>23.8</td>
<td>485</td>
<td>10.5</td>
</tr>
<tr>
<td>Queensland</td>
<td>13.1</td>
<td>436</td>
<td>9.9</td>
</tr>
<tr>
<td>South Australia</td>
<td>7.3</td>
<td>664</td>
<td>11.6</td>
</tr>
<tr>
<td>Western Australia</td>
<td>7.4</td>
<td>468</td>
<td>10.6</td>
</tr>
<tr>
<td>Tasmania</td>
<td>3.3</td>
<td>888</td>
<td>15.0</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>0.4</td>
<td>190</td>
<td>5.7</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>0.8</td>
<td>176</td>
<td>4.8</td>
</tr>
<tr>
<td>Australia</td>
<td>71.0</td>
<td>424</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Note: The annual rates were estimated by fitting a log linear model to the annual employment data.

Job openings

Growth forecasts of employment in nursing occupations are, on average, 0.4 per cent per year, over the next five years compared to 1.5 per cent for all employment. Large growth in employment is expected in the nursing managerial occupations and among registered midwives, but a contraction in employment is expected among enrolled nurses and personal care and nursing assistants. Employment of aged or disabled person carers is, however, forecasted to be 4.9 per cent per year.

Table A2.2.5 Projected growth in nursing occupations and aged and disability person carers in Australia, 2001–2006

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment level 2001 ('000)</th>
<th>Growth ('000)</th>
<th>Average annual rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All occupations</td>
<td>9090.4</td>
<td>633.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Nursing workers</td>
<td>248.4</td>
<td>4.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Nursing professionals</td>
<td>183.9</td>
<td>7.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>4.0</td>
<td>0.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Nurse educators &amp; researchers</td>
<td>2.0</td>
<td>0.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>163.5</td>
<td>5.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Registered midwives</td>
<td>10.1</td>
<td>1.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Registered mental health nurses</td>
<td>4.2</td>
<td>-0.4</td>
<td>-2.0</td>
</tr>
<tr>
<td>Registered developmental disability nurse</td>
<td>0.2</td>
<td>0.0</td>
<td>-4.3</td>
</tr>
<tr>
<td>Directors of nursing</td>
<td>2.7</td>
<td>0.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>22.5</td>
<td>-0.7</td>
<td>-0.6</td>
</tr>
<tr>
<td>Personal care &amp; nursing assistants</td>
<td>39.3</td>
<td>-2.7</td>
<td>-1.4</td>
</tr>
<tr>
<td>Aged and disability person carers</td>
<td>71.0</td>
<td>17.4</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Note: Growth forecasts are reproduced here with permission from CoPS, Monash.
Source: Table 10 and A3, Shah & Burke 2001.
The estimated jobs available to new entrants resulting from persons leaving employment (net replacement) are estimated to be 22,000, or at an annual rate of 1.8 per cent. This is lower than the rate of 2.2 per cent for the economy as a whole. The rate for enrolled nurses and personal care and nursing assistants is expected to be slightly lower than for nursing professionals.

The estimates of growth and net turnover allows calculation of the number of job openings for new entrants. Over the period 2001–06, job openings for new entrants are projected to be 31,000, about 72 per cent of them due to net turnover and only 28 per cent due to growth. The rates vary across nursing occupations with some of the highest rates for managerial occupations and registered midwives. Some of the lowest net job openings rates are for enrolled nurses and personal care and nursing assistants. However the rate for aged or disabled person carers is projected to be a very high 5.8 per cent.

Table A2.2.6 Projected net job openings in nursing occupations and aged and disability person carers in Australia, 2001–2006

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment level 2001 ('000)</th>
<th>('000)</th>
<th>Average annual rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All occupations</td>
<td>9,090.4</td>
<td>17,553.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Nursing workers</td>
<td>248.5</td>
<td>30.7</td>
<td>2.5</td>
</tr>
<tr>
<td>Nursing professionals</td>
<td>183.9</td>
<td>24.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>4.0</td>
<td>0.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Nurse educators &amp; researchers</td>
<td>2.0</td>
<td>0.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>163.5</td>
<td>21.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Registered midwives</td>
<td>10.1</td>
<td>2.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Registered mental health nurses</td>
<td>4.2</td>
<td>0.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Registered developmental disability nurse</td>
<td>0.2</td>
<td>0.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Directors of nursing</td>
<td>2.7</td>
<td>1.0</td>
<td>7.3</td>
</tr>
<tr>
<td>Enrolled nurses</td>
<td>22.5</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Personal care &amp; nursing assistants</td>
<td>39.3</td>
<td>2.9</td>
<td>1.5</td>
</tr>
<tr>
<td>Aged and disability person carers</td>
<td>71.0</td>
<td>20.5</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Note: Estimates for the smaller occupations are subject to large standard errors and should therefore be used with caution.

Source: Table 19, Shah & Burke 2001.
Attachment 2.3
Backgrounds of students commencing undergraduate nursing programs and graduate destinations

Figure A2.3.1 Basis for student enrolment in undergraduate nursing programs

- Female 88%, Male 12%
- Including:
  - Rural & remote—25%
  - Indigenous—1%
  - NESB—3%
- TAFE award (Complete/incomplete): 11%
- Higher education course (Complete/incomplete): 19%
- Secondary education: Completion of final year at school of TAFE: 37%
- Mature age entry: 8%
- Professional qualification: 14%
- Other: 10%

Note: These percentages are based on averages of figures between 1998–2000 from DEST (2002b).

Figure A2.3.2 Prediction of completions for nursing programs and graduate destinations

- Seeking full time employment: 5%
- Working full time: 76%
- Full time study: 9%
- Part time employment: 8%
- Other: 2%
- Nursing profession: 94%
- Other professions: 6%

*Note: a) Average projected 73%—Predicted Completion Rate. DETYA (1999)
  b) Proportion in workforce from 1998–2000 Graduate Destination Survey
## Attachment 2.4

### Nurse practitioners

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Date</th>
<th>Action towards implementation of nurse practitioner role</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>1996</td>
<td>NSW Health released the Nurse Practitioner Project Stage 3 Final Report (1996a). Implementation of the nurse practitioner role in New South Wales was initially proposed for public health care settings in the State’s rural and regional area health services.</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td>NSW Government announced that it was introducing a new advanced practice role for nurses.</td>
</tr>
<tr>
<td></td>
<td>October 1999</td>
<td>Amendments to the Nurses Act 1991 provided for registered nurses to apply to the NSW Nurses Registration Board to be authorised to practise as nurse practitioners, and that registered nurses may undertake a program of education at Masters Degree level recognised by the Board. The title ‘nurse practitioner’ was protected.</td>
</tr>
<tr>
<td></td>
<td>11 May 2001</td>
<td>The first nurse practitioner in NSW and Australia was appointed to an approved nurse practitioner position.</td>
</tr>
<tr>
<td></td>
<td>October 2001</td>
<td>NSW Health reported that nine nurse practitioners were authorised by the Board. Up to 40 positions (employee status) were to be considered for approval by the Director General. Four actual nurse practitioner positions had been approved at Waminda, Wilcannia, Ivanhoe and Tibooburra in the Far West Area Health Service, and 20 other positions had been ‘approved in principle’, and were undergoing development of the relevant clinical guidelines to be considered for final approval.</td>
</tr>
<tr>
<td></td>
<td>May 2002</td>
<td>The Board has presently recognised six broad areas of practice: Maternal and Child Health Nursing, High Dependency Nursing, Mental Health Nursing, Rehabilitation and Habilitation Nursing, Medical/Surgical Nursing, and Community Health Nursing. Nurse practitioners are required to be authorised by the Nurses Registration Board and re-authorised every three years. Any nurse who meets the criteria can apply for authorisation and be recognised for their expert skills. The current Board-approved courses are Masters Program in Advanced Practice in Nursing (High Dependency Nursing) at Avondale College (Wahroonga), Master of Advanced Practice Nursing (Rural and Remote) at the University of Southern Queensland (Toowoomba), and the Master of Nursing (Nurse Practitioner) at Newcastle University.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>April 2000</td>
<td>The Remote Area Nurse Practitioner Project (Western Australia—Project Report April 2000) by the Health Department of Western Australia originally proposed that the role of nurse practitioner was seen to be one for designated remote area sites (Health Department of Western Australia 2000b).</td>
</tr>
<tr>
<td></td>
<td>October 2001</td>
<td>In October 2001, under Phase 2 of the Nurse Practitioner Project, the role was broadened to include a range of settings.</td>
</tr>
<tr>
<td></td>
<td>April 2002</td>
<td>The Issues Paper—Nurse Practitioner Project Western Australia (Health Department of Western Australia 2002) advised that legislation required to enact the nurse practitioner role is in the process of being drafted, and in the interim a tender for the provision of appropriate courses had been called, and the development of a comprehensive implementation pack was underway. It is envisaged that implementation of the role of nurse practitioner in Western Australia will initially be by way of demonstration/pilot models, which will be monitored and evaluated by the Principal Nurse Practitioner at the Department of Health.</td>
</tr>
</tbody>
</table>
Victoria

1998 A Taskforce was established in Victoria by the Department of Human Services to establish a framework and process for the implementation of the nurse practitioner role in Victoria. A number of trial nurse practitioner projects were conducted in the course of the study.

July 2000 The Victorian Nurse Practitioner Project—Final Report of the Taskforce was released in July 2000. The Taskforce developed a framework for the implementation to progress the role in Victoria (Department of Human Services 2000).

February 2001 A Nurse Practitioner Implementation Advisory Committee was established. Eleven nurse practitioner models of practice were funded in the first phase of the project, and 18 models were funded as part of the second phase.

November 2001 The Victorian Government implemented the Nurses (Amendment) Act 2000 which granted the Victorian Nurses Board power to endorse eligible nurses for the nurse practitioner role and to accredit courses leading to endorsement, with 'nurse practitioner' as a protected title.

February 2002 Victorian nurses could apply to the Nurses Board of Victoria for endorsement as a nurse practitioner in the State.

At March 2002 Within the second phase of the Nurse Practitioner project, the Department of Human Services called for submissions for sustainable models of practice in targeted areas including Aboriginal health care, aged care, disability care, mental health, occupational health and safety, and maternal and child health care. Applications closed in March 2002.

South Australia

1996 The Nurse Practitioner Project was established in South Australia and a Ministerial Advisory Committee was established to advise on the appropriate means for implementation of the role.

1999 The South Australian Nurse Practitioner Project Final Report made a number of recommendations to progress implementation in that state, including the development of processes of authorisation and credentialing of nurse practitioners, and legislative changes. Under the Nurses Act 1999, the Nurses Board of South Australia created a special practice area of 'nurse practitioner'.

September 2001 The Nurses Board of South Australia endorsed the Professional Standards Statement for Nurse Practitioner Practice, the definition of 'nurse practitioner' and protection on the title. Applicants must submit a comprehensive professional portfolio and will be assessed against the Professional Standards criteria. Relevant courses available in South Australia are the Master of Specialist Nursing/Midwifery Practice (University of South Australia), Master of Nursing—Nurse Practitioner (Flinders University) and Pharmacology of Specialist Nurse/Midwifery Practice (University of South Australia).

March 2002 The Department of Human Services released an Information Kit on nurse practitioners following on from the Nurse Practitioner Project Final Report (1999). The Information Kit provides information on the Nurse Practitioner role, Regulation of Nurse Practitioners, Implementing Nurse Practitioner Positions, and Preparation for Practice, Implementation of Clinical Guidelines, Radiology Tests, Pathology Tests and Referral (South Australian Department of Human Services 2002).
<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>December 1999</td>
<td>The ACT Department of Health, Housing and Community Care established the ACT Nurse Practitioner Project Steering Committee. The committee initiated the ACT Nurse Practitioner Trial to investigate the value, safety and effectiveness of the nurse practitioner role in the ACT. The project consisted of a trial of four nurse practitioner service models in the ACT. The models were Wound Care Nurse Practitioner (The Canberra Hospital), Sexual Health Nurse Practitioner (The Canberra Hospital), Mental Health Liaison Nurse Practitioner (Calvary Hospital) and Military Nurse Practitioner (Duntroon). These trials were supervised and supported closely by a multidisciplinary team.</td>
</tr>
<tr>
<td></td>
<td>May 2002</td>
<td>The trials are now complete and information is being evaluated. Work has begun on the development of course curricula for a nurse practitioner component of a Masters in Advanced Practice Nursing at the University of Canberra, and development of a recommended list of medications for nurse practitioner prescribing. (ACT Department of Health and Community Care 2002).</td>
</tr>
<tr>
<td>Tasmania</td>
<td>January 2002</td>
<td>The Tasmanian Nurse Workforce Planning Project—Final Report, released in January 2002, (Department of Health and Human Services, Tasmania 2002) advised that the Nursing Board of Tasmania, employers and nurses should all be involved in the development of the nurse practitioner role in Tasmania. The report recommended that the nursing profession review and report on nurse practitioner models for Tasmania, that the nurse practitioner role should be clearly defined, and that the Nurses Act should be amended to protect the title ‘nurse practitioner’ to ensure that it may be used only by those people who meet the requirements of the Board.</td>
</tr>
<tr>
<td>Queensland</td>
<td>At May 2002</td>
<td>In Queensland the title ‘nurse practitioner’ is not protected. The Queensland Nursing Council is planning a project to determine the need for and regulatory framework suitable for nurse practitioners in Queensland once the National Competition Policy review of the Queensland Nursing Act is complete. Legislative changes have already been made to enable rural and isolated practice nurses to administer specific medications, and for all appropriately qualified registered nurses to order x-rays and take Pap smears. Queensland Nursing Council accredits a post-registration Rural and Isolated Practice course. Graduates of this course are eligible to apply for an endorsement authorising them to practise under the Rural and Isolated Practice Drug Therapy Protocol.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2000</td>
<td>The Northern Territory Government established a Nurse Practitioner Project to determine the feasibility of implementing the role of the nurse practitioner, and the project reported in 2000.</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>The Department of Health and Community Services, in collaboration with the Australian Nursing Federation in the Northern Territory, is currently reviewing the existing career structure for nurses within the public sector. The objective of the review is to provide nurses with opportunities for career advancement in the Northern Territory, through the development of appropriate career pathways and employment arrangements. It is expected the review will consider the role of nurse practitioners in the Northern Territory.</td>
</tr>
</tbody>
</table>
Attachment 5.1
Proposed model: Care workers—minimum education qualification

Queensland Nurses Union (QNU) supports all unregulated workers undertaking nursing practice to fulfill or be in the process of undertaking stipulated minimum educational requirements. The QNU argues the following should be included:

- competency assessment at each level of the required preparation course
- articulation to establish a career pathway for care workers into higher levels of nursing qualification
- transition processes to cover those workers already employed who do not have the required minimum qualification to allow them to continue working while gaining the qualification
- funding assistance to those workers affected by the implementation of the new minimum qualification requirement
- establishment of a framework to implement a minimum qualification requirement facilitated through the National Health and Community Services Industry Training Advisory Body (ITAB) process.

The QNU also advised that they thought a potential model for such a framework could be in the Queensland Child Care Bill and Regulation. Earlier this year the Queensland Government released an exposure draft of the new regulatory framework for child care for comment by 31 March 2002.

The proposed Child Care Bill and Regulation

The Regulation contains the specific qualification requirements for carers in child care centres that are engaged in order to meet the qualified staff/child ratios of the Regulation. The Regulation:

- requires that all qualified carers will be a minimum of 18 years of age, unless they are assistants who are 17 years of age and studying towards the minimum qualification
- sets out the qualification requirements for different levels of staff in centre-based services
- stipulates that any staff employed without the minimum qualification must commence a qualifying course within six months of being engaged, and complete the qualification within three years

The Bill and Regulation sets out record keeping obligations. For instance, the Bill requires that people working in child care services will be required to have a suitability notice, and that the licensee of a child care service will be required to keep originals or certified copies of the suitability notices of their staff as part of their records. The Bill contains all of the inspectorial powers necessary to ensure that officers of the Queensland Department of Families have the power to monitor child care services, including power of entry.

The Bill contains requirements that role statements have to be prepared and maintained in regard to positions in the child care service.

The Bill and Regulations also contain transitional arrangements.

- Staff of child care services who are unqualified or do not have the necessary minimum qualification will have six months to commence study and three years to complete the qualification. In the meantime they will be permitted to continue working in the position.
• Staff who are over 45 years of age when the current Regulation commenced in June 1992 (that is, they are now 54 years of age) and who are working in a senior position within the child care service (director, assistant director or group leader), and who not have the necessary minimum qualifications may continue to work under the new legislation and do not need to undertake additional study.

• Those childcare workers who were not actually employed when the new legislation commences will be required to meet the same qualification requirements as newly employed staff when they commence/recommence work in a child care service.
Attachment 5.2

Research bodies

There are three main research bodies that have relevance to nursing:
- the National Health and Medical Research Council (NHMRC)
- the National Institute of Clinical Studies Ltd (NICS)
- the Australian Research Council (ARC).

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is a statutory body within the Health and Ageing portfolio with principal responsibility for advising the Australian community and Commonwealth, State and Territory governments on standards of individual and public health, and supporting research and research training to improve these standards. The NHMRC Research Program covers health and medical research, including biomedical, clinical and public health. It provides research support through a variety of mechanisms including support for individual research projects, broad programs of research, training awards and fellowships and special research units.

The 1999–2000 Budget included an additional allocation of $614 million over six years to double the funding of the NHMRC. The 2002 allocation of funds totalled $366,695,000.

Since 1997, the NHMRC has set aside funding to develop strategic capability in areas where research is currently under-developed, or where there are gaps in the current effort. This research funding is administered by the Strategic Research Development Committee, one of the four principal committees of the NHMRC. Specifically, the Committee is responsible for:
- defining a research, and research training, agenda based on identified gaps in knowledge and skills
- enhancing the national research capacity, skills and institutional capability to respond in a focused and timely fashion to emerging health research needs
- developing the national capacity to identify, target, generate and link research-based knowledge which is applicable to programs, policies and interventions
- fostering the ability to evaluate the application of research-based knowledge to programs, policies and interventions in medicine and public health.

The current terms of reference for the Strategic Research Development Committee were approved for the 2000–2003 triennium. The Committee will be conducting consultations in the second half of 2002 to inform their development and refinement of research priorities for the next triennium.

National Institute of Clinical Studies Ltd

In December 2000, the then Department of Health and Aged Care established the National Institute of Clinical Studies Ltd (NICS), committing $1.5 million to establish the Institute and a further $3.5 million per annum for three years to implement its Strategic and Business plans.

The Institute is to provide a national, integrated focus for work being undertaken to continuously improve the quality of clinical practice and its delivery to patients. The work of Institute is to be complementary to groups such as the NHMRC, the Australian Council for Safety and Quality in Health Care (ACSQHC), the Medicare Services Advisory Committee, the Pharmaceutical Benefits Advisory Committee and the National Health Priorities Action Council. It aims to:

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Our Duty of Care
• identify areas where greater consistency between evidence and clinical practice will improve outcomes, and to advocate on priority areas for action
• develop and test solutions throughout different levels of the healthcare system that will assist the clinical workforce to close the gap between evidence and clinical practice
• encourage adoption, throughout the health system, of solutions that are known to be effective in achieving change at the clinician, organisation and system level
• support the development of infrastructure, which will ensure that solutions that improve clinical practice and are designed to close the gap between evidence and practice are sustainable and lead to a culture of change.

The Institute is committed to the involvement of all professions involved in the delivery and administration of patient care in its work and will engage nurses from all clinical specialties for expert advice as required. The Institute has established a reference group of nurses which held its first meeting in February 2002.

The nursing reference group is to:
• provide advice on a nursing consultation and communication plan for the Institute so that it can incorporate the views of nursing within its strategic directions and can efficiently and effectively communicate with nurses about its activities
• identify initiatives/projects focused on applying current research knowledge to clinical practice that are of particular relevance to nursing, and advise on the best ways to develop potential initiatives/projects
• offer advice on key issues relevant to nursing disciplines for identified priority areas
• recommend the names of clinicians and key clinical leaders, or ways in which the Institute might identify these people, in areas where it is undertaking or considering particular initiatives and projects.

The Australian Research Council

The Australian Research Council (ARC), an independent body, is responsible for the National Competitive Grants Program which includes Discovery Grants and Linkage Grants. Discovery Grants support fundamental or basic research while Linkage Grants support collaboration with other universities, research agencies and industry. The allocation for the program for 2003 is $339.2 million and for 2004 is $385.7 million. In addition to the continued support for research in fundamental and applied areas, both outstanding individual research projects and new ARC Centres will be funded, drawing on both discipline-specific and cross-disciplinary approaches.

Funding levels for priority areas will be higher than they have been in the past, and their share of funding will rise relative to other areas. The ARC research priority areas for the 2003 funding round are Nano- and Bio-materials, Genome/Phenome Research, Complex/Intelligent Systems, and Photon Science and Technology. The quantum identified for priority areas is 33 percent of the ARC's 2003 funding round, covering grants commencing in 2003 through to 2007, and totalling between $150-$170 million.
Attachment 5.3
Research funding

There is a need for additional funding, firstly for research, and secondly to support the improved integration of research findings into nursing practice through the health, community and aged care sectors.

The additional funding for research is intended to include two elements:

- support for research centres in important areas, which would enable a longer term focus on key research areas, research training, links with other organisations including internationally in their areas of particular expertise, and sustained inter-activity with policy makers, practitioners and other researchers.
- research grants available for competitive allocation, perhaps assessed against a list of national priority areas in nursing, but also including some opportunity for consideration of high quality research in any area of nursing.

A research centre would require a minimum core of staff (perhaps five to ten), depending on the particular area of research and appropriate support (not all necessarily full-time). This might involve a core budget of perhaps $500 000 per annum per centre. The core budget would be supplemented by successful bids for additional project grants. These project grants could come from diverse sources, including Commonwealth, State and Territory governments (including but not restricted to the health, aged care and community sectors), private providers, general research funding bodies, foundations and other sources.

It is envisaged that the centres would be funded for five years in the first instance, with the opportunity for continuation, depending on their research achievements and future proposals. It would be desirable for the Commonwealth authorities to encourage matching contributions where possible, either in cash or in kind. This has previously occurred for other centres funded, for example, by the National Health and Medical Research Council.

We recommend that funds be available over a five-year period initially. These might be from some $5 million in the first year (of which some $3 million would be required in core grants if six research centres were established, with a similar amount available for project grants), amounting to something like $20 million in total over five years.

Finally, since the primary purpose of the increase in research funding is to improve nursing policy and practice in Australia, it is suggested that consideration be given to dissemination, the implementation of research findings and sustained inter-activity between researchers, policy makers and practitioners. This element could be incorporated routinely in most of the research projects that are funded. However, especially in the early years, particular studies might investigate how this sustained interactivity might be achieved. A sum of $1 million is suggested for this purpose in the initial year, with subsequent allocations being determined in the light of experience.
Attachment 6.1
State and Territory Government nursing initiatives

Overview of some State and Territory health department initiatives
The following does not report on all that is happening for the nursing profession in the States and Territories. However, this overview of the various State and Territory health department initiatives provides an indication of the range and diversity of nursing strategies currently in place in Australia. Information on the State and Territory projects related to the role of ‘nurse practitioner’ is at Attachment 2.4

Queensland Health

www.health.qld.gov.au
The 1999 Final Report, Ministerial Taskforce on Recruitment and Retention (Queensland Health, 1999) made recommendations on a number of strategies to deal with nursing workforce issues. Since that time, Queensland Health has been working towards the implementation of recommendations from that report including establishment of a nursing career advisory service and various education programs, development of transition support processes for new nursing graduates, and trialing of alternative rostering practices.

In December 2001 the Minister for Health launched the ‘Think Nursing’ internet site at <www.thinknursing.com>. This site provides online information on a range of topics related to nursing in Queensland, including a database of employment opportunities available for nurses. The site is geared to recruitment and has specific information sections for school students, Indigenous students, university and TAFE undergraduates, registered and enrolled nurses, and career advisors and work experience coordinators for further education and career pathways. It also has vignettes on ‘a day in the life’ of particular nurses.

Queensland Health also provides support for nursing education and re-entry programs. The Queensland Health Nursing Re-entry Assistance Scheme (QHNRAS) has been developed to help nurses re-enter the Queensland Health workforce following periods of absence. The scheme provides for the employment of QHNRAS candidates in Queensland Health facilities while they undertake re-entry requirements with the Competence Assessment Service. The Queensland Health Rural Scholarship Scheme also provides support to all students, with a commitment to health provision in rural and remote Australia. Scholarships for nursing and Indigenous nursing undergraduate students include components for living allowance, academic fees and an annual travel allowance.
NSW Health

www.health.nsw.gov.au

NSW Health, in partnership with the NSW Nurses' Association, nursing organisations, health services and the nursing education sector has progressed a range of initiatives and strategies aimed at increased recruitment and retention of nurses in New South Wales. A small selection of these include:

- the establishment of the Ministerial Nursing Recruitment and Retention Taskforce
- NSW Ministerial Standing Committee on Nursing Workforce
- the Enrolled Nurse Review
- the Midwifery Taskforce
- the Peak Nursing Forum.

The NSW Ministerial Standing Committee on the Nursing Workforce (MSC) was established in early 2000. An Action Plan was developed in September 2001, which presents a range of strategies to create a supportive environment for nurses and consumers in New South Wales. Some of the issues being considered are (but not limited to) the prevention and management of violence in the workplace, child care issues concerning all health workers, research about workload within the workforce, and a range of factors affecting recruitment and retention. The Committee established the NSW Health's Reconnect Program, which funds general registered nurse, enrolled nurse, and midwifery refresher courses to facilitate re-entry into the nursing workforce for those who have not worked in nursing for a number of years (NSW Health 2002).

The department allocates funds to the Office of the Chief Nursing Officer (OCNO) for a range of support initiatives for nursing. NSW Health has a comprehensive website, 'Nursing Info', at <www.health.nsw.gov.au/nursing>. The office is involved in a number of projects, including the Nurse Practitioner Project, Nursing Workforce Modelling, Mental Health Projects, and the NSW Rural and Remote Aboriginal Nursing Project. Other initiatives include transitional support for new general and midwifery graduates, and orientation programs for specialty clinical areas. The OCNO also negotiates an annual contract with the NSW College of Nursing for the provision of a range of postgraduate certificate courses for registered nurses and specialty continuing education programs for enrolled nurses.

At the Area Health Service level there are a number of educational strategies in place for nursing including preceptor and mentoring programs, specialty skills development programs, mental health programs, local refresher programs, continuing education programs, and programs in partnership with either the tertiary sector or the NSW College of Nursing (NSW Health 2001c).

Further, NSW Health supports the NSW Nursing Scholarship Fund to assist in the recruitment and retention of nurses in rural and remote areas of New South Wales. Subject to budget approval each year, the fund currently provides for scholarships to first year undergraduate nursing students with a rural background; rural placement grants to undergraduate nursing students with a rural or urban background studying at a New South Wales or approved university who undertake a clinical placement in a rural or remote area of New South Wales; and postgraduate scholarships to registered nurses employed in the New South Wales public health system who undertake study in a nursing course at a New South Wales or approved university.
Health Department of Western Australia

www.health.wa.gov.au

The Health Department of Western Australia has a web page 'Nursing in WA' at <www.nursing.health.wa.gov.au/nvnd/index.cfm>. This site provides useful links for information on projects, scholarships/funding, and on the department's recent study on nursing and midwifery in Western Australia, New Vision, New Direction (Health Department of Western Australia 2001). This study addressed five key focus areas: workforce issues, professional standards, education, professional practice and leadership. It presented a series of recommendations to be implemented in a coordinated approach between all key stakeholders, and these are now being progressed by the department. Linked to the 'Nursing in WA' page is 'Nurse-Link' <www.nursing.health.wa.gov.au/reentry/index.cfm>, funded by the department to provide professional advice and support to nurses to return to the government health industry nursing profession. 'Nurse-Link' offers nurses contact with a nurse recruitment specialist who will provide advice, support and information (to suit each nurse's personal requirements) on re-fresher and renewal of registration courses, contact people for courses and current employment vacancies.

The department offers a range of undergraduate nursing scholarships, and also postgraduate nursing and midwifery scholarships in areas such as professional development, remote area nursing, and child health. Scholarships are also available in postgraduate mental health nursing, and for enrolled nurses to undertake professional development studies. In recent years the department has conducted a number of nursing projects in response to the needs and requests of the profession including a Homebirth Policy Review Project, Enhanced Role Midwifery, Nurse Practitioner Project, Advance Practice Nursing Working Party, and the Nurse Pap Smear Providers Credentialing Project.

Also of note is the successful recruitment campaign Are You Good Enough To Be A Nurse?, which was first launched in 1999. The aim of the campaign is to challenge secondary school students' negative perception and stereotypes of nursing and nurses and to provide a realistic and positive view of the nursing profession. The campaign targets students, career advisers and parents.

South Australian Department of Human Services

www.dhs.sa.gov.au

In recent years the South Australian Department of Human Services has approved funding of a number of nursing initiatives including (but not limited to) a marketing campaign, refresher and staff development for rural and remote nursing staff, and telemedicine. Other funding support is by way of Graduate Nurse Programs at public hospitals, a Nursing Career, Employment and Education Expo, and Nursing Excellence Awards.

The department provides a website on 'Nurses in South Australia' at <www.dhs.sa.gov.au/nursetabour/>. The website brings together information for nurses through links to labour force bulletins, nursing data and statistics (including nurse workforce tables), different workforce planning and information reports and fact sheets, and information on scholarships. In recent years the Office of the Chief Nurse has prepared a number of reports on nursing student intake and training requirements for aged care nursing, critical care nursing, enrolled nurse, midwifery, and undergraduate nursing courses, and the website also has a link to the department's Nurse Practitioner Project. For information on careers in nursing, the department has also developed the Nursing Takes You Places website at <www.nursingsa.com/> as part of its Nurse Marketing Campaign.

Two recent initiatives developed by the South Australian Department of Human Services are for Year 10 to 12 students in metropolitan and rural secondary schools and colleges throughout South Australia. The first is the Nurses Speaking in Schools Program, where young nurses from a variety of
clinical settings have been recruited and trained to speak in schools to promote nursing as a career option to secondary school students. The other program is the Nurse Job Shadowing (Work Experience) Program, a structured program developed to give students interested in a career in nursing the opportunity to experience a taste of the working life of a nurse in a healthcare setting.

Department of Health and Human Services, Tasmania

www.dhs.tas.gov.au

The Final report of the Tasmanian Nurse Workforce Planning Project (Department of Health and Human Services, Tasmania 2001) combines the efforts of a number of Working Groups on the project. The report examined the current nursing workforce, and current and future needs, and addressed a range of issues about nursing recruitment and retention, nursing education and regulation, and nursing data and workforce profile.

The department's Careers in Nursing website Caring Through Life is at <www.dhhs.tas.gov.au/jobsandcareers/index.html>. This site has information on nursing education and nursing workforce opportunities, and a link to the department's 'Employment Register for Nurses and Health Professionals', which also contains information on different nurse practice settings throughout Tasmania, such as rural and remote; community and mental health; family, children and youth health; and public and environmental health.

The department provides Graduate Nurse Development Programs in three acute teaching hospitals and also in primary health care settings such as community nursing, mental health and rural hospitals, in conjunction with hospital graduate programs. The department also has a strategic partnership with the University of Tasmania Faculty of Health Sciences 'Partners in Health' initiative. Its aim is to improve health services in Tasmania through a coordinated approach to education, research and clinical service delivery. Outcomes of this partnership include a First Line Emergency Response Program, a Development Program for Rural and Remote Midwives, a Pharmacology Package for Registered and Enrolled Nurses and University of Rural Health Teaching Sites (which provide accommodation), and telehealth facilities for undergraduate and postgraduate students undertaking clinical practice in rural areas.

The department also provides scholarships of up to $3300 to cover the costs of the Re-Entry to Practice Program, which a nurse needs to complete in Tasmania if they have had a break in practice of more than five years, and would like to return to the workforce.

Department of Human Services (Victoria)

www.dhs.vic.gov.au

The Department of Human Services has a number of strategies in place to help nurses return to the workforce, including funded refresher/re-entry programs, improved nurse-patient ratios to reduce workload, scholarships for postgraduate study and study leave for Division 1 and 2 nurses.

In May 2001 the Department released the Nurse Recruitment and Retention Committee – Final Report (Department of Human Services 2001). In response to this report, the Committee developed a statewide Nurse Recruitment Strategy including a $2 million advertising campaign. The broad objective of the strategy is to help nurses return to the public health system. Public facilities and the Australian College of Midwives can be offered $2100 for every nurse placed on a Nurses Board of Victoria accredited course to regain registration. Nurses completing re-entry and supervised practice programs are entitled to up to $2200 depending on the nurses travel...
requirement. By February 2002, 3300 permanent nurses had been attracted into Victoria's public hospital system since July 2000. Also as part of the strategy, in 2001 the number of Division 2 (enrolled nurse) places in the Vocational Education and Training sector was doubled to more than 2000, and a number of scholarships have been funded for postgraduate study in critical care nursing specialisations.

The Nurse Policy Branch of the Department of Human Services manages the 'Nursing in Victoria' website at <www.nursing.vic.health.gov.au>. The site disseminates information on project developments and current issues under consideration and reports on policy development. The site is intended as a resource for registered nurses and those considering either pursuing a nursing career or for former nurses wishing to rejoin the profession. The department also has a web page, 'Victorian Hospital Employment', to provide information on nursing vacancies, and career and skills development programs available. Under its Training and Development Grant (nursing component), the department provides funding to hospitals to recognise the additional costs of hospitals that conduct graduate nurse programs, postgraduate nurse programs, courses for student midwives, and continuing nurse education courses.

The Nurse Policy Branch is also facilitating the process for review and implementation of an extended scope of practice for the Division 2 Registered Nurse following a review undertaken by the Nurses Board of Victoria, reported in Extended Scope of Practice in Medication Administration for the Division 2 Registered Nurse May 2000 (Nurses Board of Victoria 2001).

Department of Health and Community Services (Northern Territory)

www.health.nt.gov.au

The website for the Department of Health and Community Services in the Northern Territory includes a number of career fact sheets on enrolled nurses, registered nurses, remote area nurses (for Central Australia), and nursing education and training coordinators, under its Careers and Vacancies web page. The department also provides funding for a number of Studies Assistance Grants to cover course fees (excluding HECS), conference registration fees, test books and equipment, travel costs and related accommodation.

The department, in collaboration with the Australian Nursing Federation, is currently reviewing the existing career structure for nurses within the public sector in the Northern Territory. In identifying and removing barriers, the objective of the Nursing Career Structure Review is to provide nurses with opportunities for career advancement through the development of appropriate career pathways and employment arrangements. The review process is in its final stages and is on track to be finalised and ready for implementation by July 2002. It is anticipated that implementation will occur over a three to six month period. Information on the career structure can be found at <www.nt.gov.au/health/org_supp/wp/ncsr.shtml>.

ACT Department of Health and Community Care

www.health.act.gov.au

The ACT Department of Health and Community Care provides a number of scholarships for nurses for postgraduate studies in nursing specialties where there is an identified area of need, and for re-entry/refresher programs. Funding is available for nurses who wish either to undertake a masters degree, graduate diploma or graduate certificate course of study in a field of clinical nursing, or to undertake the re-entry Refresher Course Program at the University of Canberra.
### Attachment 6.2

#### Department of Health and Ageing

nursing scholarships and assistance packages

<table>
<thead>
<tr>
<th>Program of scholarship/ workforce initiative</th>
<th>Aim of program</th>
<th>Length of program</th>
<th>Target group</th>
<th>Number of scholarships/ assistance packages</th>
<th>Value of program/ scholarships</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Aged Care Nurses 2002–2003 Budget Statement</td>
<td>To encourage people to take up nursing or to re-enter nursing in the aged care sector</td>
<td>2002–03 to 2005–06</td>
<td>Undergraduate nursing through rural and regional university campuses</td>
<td>Up to 250</td>
<td>$26.3m over four years</td>
</tr>
</tbody>
</table>

| Support for Aged Care Workers 2002–2003 Budget Statement | To access education, training or up-skilling opportunities. Development of long-term National Aged Care Workforce Strategy | 2002–03 to 2005–06 | Care workers in aged care in smaller, less-viable aged care homes | Up to 10 000 | $21.2m over four years |

| Commonwealth Remote and Rural Scholarship Programs—Undergraduate Scheme | To improve access to full-time undergraduate nursing education for remote, rural and regional students | 2001–05 | Remote, rural and regional students | Up to 110 scholarships per annum (10 scholarships specifically for Indigenous students) | $13m over four years ($10 000 per student per annum) |

Up to $5000 for students suffering exceptional (financial) hardship.
Additional $2.1m to support measures associated with scholarships including mentor/peer programs, additional financial assistance and cultural awareness training.
### Commonwealth Remote and Rural Scholarship Programs—Post Graduate Scheme

To assist rural and remote nurses to build on their knowledge of current clinical issues and offer opportunities to expand their professional networks.  
Expires June 2002 but negotiations to continue the program after that time underway  
Registered and enrolled nurses  
Up to $600 000 per annum  
Amount of scholarship determined on an individual basis

### Commonwealth Remote and Rural Scholarship Programs—Re-entry and Upskilling Scheme

To remove some of the financial barriers to nurses working in rural and remote areas for re-entry into the non-acute, private sector workforce  
2002–06  
Registered or enrolled nurses  
$5.2m over four years  
200 scholarships of $6000 each

### Puggy Hunter Memorial Scholarship Scheme

For nursing, medical, and Aboriginal Health Worker students (nursing and medicine only in 2002)  
2002–06  
Aboriginal and Torres Strait Islander students  
44 scholarships over period of program  
$10 000 per student per annum, plus up to $5000 per annum to each student as a disadvantaged supplement.

### General Practice Nurses 2001–2002 Budget statement

To enable general practices to employ practice nurses, and for training and professional support of practice nurses  
2001–05  
General practices in areas of high work pressure to employ more nurses.  
$86.6m over four years to general practices to employ more practice nurses  
$12.5m for training and professional support of practice nurses
Attachment 8.1
Leadership and management courses and programs

Leadership/management postgraduate courses

The report, Nursing education and graduates: Profiles for 2001, with projections for 2002 (Ogle et al. 2001), commissioned by the Review, advised on a range of postgraduate courses in Australia that have specifically designated postgraduate programs in ‘functional nursing’ specialties (health services management, applied management, nurse education, nursing administration, nursing leadership, clinical education, nurse practitioner, and clinical teaching).

As one example, a Master of Nursing Leadership Program is offered by the Australian Catholic University at its campuses in Victoria, New South Wales and Queensland. The core units of the program aim to provide a foundation in theory and practice of leadership in nursing, while elective units focus on a particular aspect of nursing leadership (Nursing Management, Nursing Futures, or Nursing Research). A table of programs specifically designated as courses in ‘functional nursing’ (taken from information presented in the report by Ogle et al. 2001) follows. (Note: It is expected that masters programs in Nursing or Health Sciences offered by various institutions may also contain streams in leadership/management.)

Table A.8.1.1 Nursing leadership programs at universities

<table>
<thead>
<tr>
<th>State</th>
<th>University</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Australian Catholic University</td>
<td>Master of Nursing Leadership</td>
</tr>
<tr>
<td></td>
<td>La Trobe University</td>
<td>Postgraduate Diploma in Advanced Nursing Leadership</td>
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<tr>
<td></td>
<td></td>
<td>Nursing Management</td>
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<tr>
<td></td>
<td>Monash University</td>
<td>Graduate Certificate of Nursing Management</td>
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<tr>
<td></td>
<td>University of Ballarat</td>
<td>Master of Health Services Management</td>
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<tr>
<td>New South Wales</td>
<td>Avondale College</td>
<td>Graduate Diploma/ Master of Nursing Administration</td>
</tr>
<tr>
<td></td>
<td>Australian Catholic University</td>
<td>Graduate Certificate/ Diploma/ Masters in Clinical Nursing</td>
</tr>
<tr>
<td></td>
<td>Charles Sturt University</td>
<td>Graduate Certificate in Health Science— Nursing Education</td>
</tr>
<tr>
<td></td>
<td>University of Newcastle</td>
<td>Master of Applied Management (Nursing)</td>
</tr>
<tr>
<td></td>
<td>University of New England</td>
<td>Master of Nursing in Advanced Clinical Education</td>
</tr>
<tr>
<td></td>
<td>University of Technology, Sydney</td>
<td>Graduate Diploma in Nursing Management</td>
</tr>
<tr>
<td></td>
<td>NSW College of Nursing</td>
<td>Graduate Certificate/ Diploma/ Master of Health Services Management</td>
</tr>
<tr>
<td>Queensland</td>
<td>Australian Catholic University</td>
<td>Master of Nursing Leadership</td>
</tr>
<tr>
<td>South Australia</td>
<td>Flinders University</td>
<td>Master of Nursing (Nurse Practitioner)</td>
</tr>
</tbody>
</table>
ICN Leadership for Change Project

The ICN Leadership for Change Project (the LFC Project) (ICN 2002c) has been put forward as a program that could work well in Australia because of its potential to bridge the distances between nurses in rural areas and those unable to join industrial or professional support groups because of economic or geographic constraints. The program is modified to suit different countries, and aspects of the program could be modified to suit nurses in Australia.

The LFC Project commenced in 1996, and includes a number of strategies focusing on policy development, management and leadership in nursing and health services, and the role of nurses in preparing future nurse leaders. The LFC Project helps senior nurses at country or organisational level participate in policy development and decisions, be effective leaders and managers in nursing and health services, prepare future nurse managers and leaders for positions of influence in changing health services, and influence changes in nursing curricula so future nurses are prepared appropriately.

The ICN first developed the program for Latin American and Caribbean countries, but has now expanded to the South Pacific, Africa, Singapore and, most recently, Bangladesh (ICN 2002b). An ICN Evaluation Committee is currently undertaking a four-stage evaluation of the program (Stage 3 has been completed).

The Health Leaders Network

The Health Leaders Network (HLN) is the trading name of the ANZ Health Management Network, which was established in 1997. The HLN operates across Australia and New Zealand and operates under the auspices of the Australian Health Ministers Advisory Council. It provides learning programs for health leaders in Australia and New Zealand, unavailable elsewhere, and its objectives are to develop, network and extend health leaders (Health Leaders Network 2002).

The Network offers a range of events including workshops, forums, sharing ideas symposiums, study tours, courses and conferences covering current issues, major developments and leadership in healthcare for senior health leaders in the public and private sectors. It operates The Australian & New Zealand Health Leadership Program, which provides an opportunity for senior health professionals to enhance their leadership skills and capabilities and comprises an intensive and challenging series of four modules held across the calendar year. This program is in its fifth year. In 2001 some events the HLN presented were a Leadership for Clinicians program, a Building Clinical Leadership program, and a seminar Looking for Solutions—Leadership, Nursing, Safety, and Quality, which focused on the recruitment and retention of nurses.

The HLN’s primary focus is on the leadership development needs of chief executive officers, clinicians, senior managers, and senior bureaucrats from the publicly funded health sector. The target group also includes a wide array of health leaders, such as those in clinical areas, Indigenous health and in primary care, and those who may not necessarily be in formal executive management positions yet have the ability, through their leadership role, to influence the attitudes of their colleagues. The Network places particular emphasis on bringing together various target groups, especially managers and clinicians who must work across the interface that sometimes divides them.

The HLN also involves senior executives in health funds and private hospitals, and others from the private health sector. These programs focus on providing knowledge on leading edge global and local developments in health care policy and practice, and leadership skills to implement this knowledge for the benefit of continuing improvement in the health status of all Australians and New Zealanders.
NHS Leadership Strategy and National Leadership Centre

When considering a national leadership strategy, the Review noted a strategy which was announced under the new National Health Service (NHS) Plan in the United Kingdom in 2000 (NHS 2000), and which allows front-line nurses, midwives and health visitors to build upon their leadership skills (NHS 2002a). As part of this strategy, a National Leadership Centre was established in April 2001, incorporating a National Nursing Leadership Project. The National Nursing Leadership Project team coordinates the Leading Empowered Organisations (LEO) Program and the Royal College of Nursing (RCN) Clinical Leadership Program nationally. The key objective of the project is to ensure that targets laid out in the NHS Plan are met and that over 32,000 clinical leaders will experience leadership training within the next two years on one or more of these programs. The National Nursing Leadership Project will be working across multi-professional teams with allied health professionals and others in health care settings such as prisons (NHS 2002b).

Royal College of Nursing Clinical Leadership Program

The RCN program is patient-centred, practical, needs-led and consistent with the NHS Plan. Its aim is to assist healthcare practitioners develop patient-centred leadership strategies to deal with the realities of their day-to-day practice. The program runs over 18 months and involves the release of clinical leaders for 25 per cent of their time. A local facilitator is also required to devote 100 per cent of their time to the program for its duration.

The program uses a mixture of workshops, action learning, observation of care and patient stories. Participants also use techniques such as shadowing, personal development planning, team role audit and team action planning. It is expected that participants will develop the ability to manage time, workload and team relationships, work effectively with colleagues across professional and organisational boundaries, and understand and influence the political and managerial agendas with the organisation.

The RCN works with a number of organisations over a one-year period, supporting one senior nurse and 12 local clinical leaders to develop and implement practical strategies to improve patient care. Through feedback, one-to-one supervision, action learning and exploration of the organisation of care, the participants are able to increase their self-awareness to produce individual personal development plans.

Evaluation confirms that the program is making a difference—participants are more self-confident, are empowered to lead their teams, and are motivated despite the difficult circumstances in which they are often working. The preliminary findings also indicate that this practical approach has improved the effectiveness of the clinical leaders and that they become more patient-focused.

Leading an Empowered Organisation

Leading an Empowered Organisation (LEO) is a three-day program that is designed for healthcare professionals from all disciplines and with all levels of expertise and experience. LEO is offered by the Centre for the Development of Nursing Policy and Practice at the University of Leeds, in partnership with the originators of LEO, Creative Healthcare Management, based in Minneapolis.

The philosophy of LEO is based on principles of respect, dignity and empowerment. Empowerment is defined as creating an environment in which people can behave as responsible adults. Therefore, LEO encompasses the principle of accountability by assisting participants to clearly define responsibility and authority for their work.

LEO can support Registered Nurses and charge nurses and front-line team leaders to lead and effect change in their organisations. To date, almost 20,000 charge nurses and sisters have completed the LEO program, a number that is expected to double by November 2002, well in excess of the 32,000 national target.
Abbreviations

ABS     Australian Bureau of Statistics
ACCNS    Australian Council of Community Nursing Services
ACDON    Australian Council of Deans of Nursing
ACMI     Australian College of Midwives Incorporated
ACSQHC   Australian Council for Safety and Quality in Health Care
AHMAC    Australian Health Ministers' Advisory Council
AHWAC    Australian Health Workforce Advisory Committee
AHWOC    Australian Health Workforce Officials Committee
AIHW     Australian Institute of Health and Welfare
AIN      Assistant in Nursing
ALSO     Advanced Life Support in Obstetrics
AMCI     Australian Midwifery Council Incorporated
AMSANT   Australian Medical Services Alliance, Northern Territory
ANCI     Australian Nursing Council Incorporated
ANF      Australian Nursing Federation
AN TA    Australian National Training Authority
ANZCMHN  Australian and New Zealand College of Mental Health Nurses Incorporated
AQ F     Australian Qualifications Framework
AQTF     Australian Quality Training Framework
ARC      Australian Research Council
ASCO     Australian Standard Classification of Occupations
AVCC     Australian Vice Chancellors Committee
CATSIN   Congress of Aboriginal and Torres Strait Islander Nurses
CHIPS    Care and Health Industries Pathways for Schools
CRANA    Council of Remote Area Nurses of Australia
DEET     Department of Education, Employment and Training (Commonwealth)
DEST     Department of Education, Science and Training (Commonwealth)
DETYA    Department of Education, Training and Youth Affairs (Commonwealth) until Nov 2001
DEWR     Department of Employment and Workplace Relations (Commonwealth)
ECF      Enterprise and Career Education Foundation
EFTSU    Equivalent Full-Time Student Unit
EN       Enrolled Nurse
GDP      Gross Domestic Product
GP       General Practitioner
HACC  Home and Community Care
HACSU  Health and Community Services Union
HECS  Higher Education Contribution Scheme
HIC  Health Insurance Commission
ICN  International Council of Nurses
ICT  Information and communication technologies
ITAB  Industry Training Advisory Body
MCEETYA  Ministerial Council for Education, Employment, Training and Youth Affairs
MINCO  Australian National Training Authority (ANTA) Ministerial Council
NENA  National Enrolled Nurse Association
NHS  National Health Service (UK)
NICS  National Institute of Clinical Studies
NCIS  National Career Information System
NCVER  National Centre for Vocational Education Research
NHMRC  National Health and Medical Research Council
NNOs  National Nursing Organisations
NRHA  National Rural Health Alliance
NTF  National Training Framework
OECD  Organisation for Economic Co-operation and Development
OATSIH  Office of Aboriginal and Torres Strait Islander Health
PBS  Pharmaceutical Benefits Scheme
PCA  Personal Care Assistant
PELS  Postgraduate Education Loan Scheme
QNC  Queensland Nursing Council
RCNA  Royal College of Nursing, Australia
RN  Registered Nurse
RTO  Registered Training Organisation
RTS  Research Training Scheme
TAFE  Technical and Further Education Training Institution
TER  Tertiary Entrance Rank
VET  Vocational Education and Training
WHO  World Health Organization

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References

ABS— see Australian Bureau of Statistics

ACS QHC— see Australian Council for Safety and Quality in Health Care


AIHW— see Australian Institute of Health and Welfare


ANCI— see Australian Nursing Council Incorporated

ASTA— see Australian National Training Authority


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DEEryA—see Department of Employment, Education, Training and Youth Affairs


DEETYA — see Department of Education, Training and Youth Affairs

ECEF—see Enterprise and Career Education Foundation
Health Department of Western Australia (1997) Attracting Nurses Back Into the Nursing Workforce. Report by Biztrac, Edith Cowan University for the Health Workforce Reform Division. Perth: Health Department of Western Australia
Health Department of Western Australia (2000a) Health 2020: A Plan for Metropolitan Perth. Perth: Health Department of Western Australia
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HIC — see Health Insurance Commission


ICN — see International Council of Nurses


NHS—see National Health Service


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WHO—see World Health Organization


Appendix A
Terms of Reference and Reference Group

Background

Nursing education is a matter of interest to both State and Commonwealth governments. The initial education and training of registered and specialist nurses is principally the responsibility of universities, primarily funded by the Commonwealth education portfolio. The training of enrolled nurses (known as Division II nurses in Victoria) occurs in the Technical and Further Education Institutions (TAFEs) of the States and Territories. State and Territory governments have a direct interest in their role as the foremost employers of nurses. Nursing workforce issues are matters for the Commonwealth, State and Territory health portfolios. These various responsibilities in relation to education policy, funding and employment all impact on nursing education.

In August 1984, in line with the global movement of preparatory nursing courses into universities, the Commonwealth announced its in-principle support for the transfer of registered nurse preparation from the hospitals into the higher education sector. This transfer was a staged process with different States and Territories changing at different times, but the transfer was complete by the end of 1993.

In 1994, a review of nursing education in Australian universities examined the outcomes of this transition, in particular, the provision of wider professional preparation and increased career choices for nurses. The findings of the review were that the effects of the transfer of nurse education to the universities had been uneven. The review also found that the broader professional preparation of nurses had been an achievement of the transfer, but tensions between this preparation and the conditions of institutional employment existed. Further, there were outstanding issues of the status of nursing in the universities and the relationships between the various stakeholders and their divergent expectations.

Since that review, issues of the nexus between nursing education and the demands of the labour market have become a focus of concern. There appear to be general nursing workforce shortages as well as shortages in some specialist areas. Other factors affecting the nursing labour market include the demands of new technologies; clients' expectations; status, pay and conditions; and the increasing demand for chronic and disability nursing as the population ages. The reduced level of interest of school leavers in nursing as a career, the cost of nursing preparation, the changing demands of the labour market in terms of the types of knowledge and skills required and the timing and distribution of those needs, create a highly complex relationship between the education of nurses and the labour market. This is an appropriate time to examine these issues through a review of nursing education to ensure that nursing education meets the needs of the changing labour market.

Terms of reference

(1) Against this background the Review will examine: the effectiveness of current arrangements for the education and training of nurses encompassing enrolled, registered and specialist nurses; factors in the labour market that affect the employment of nurses and the choice of nursing as an occupation; and the key factors governing the demand for, and supply of nursing education and training.
The Review will specifically make recommendations on:

(a) models of nurse education and training to meet the emerging labour force, including practical training, processes for articulation between different levels of competency and professional expertise and re-entry into the workforce
(b) the types of skills and knowledge required to meet the changing needs of the labour force involved in nursing, and
(c) mechanisms for both attracting new recruits to nursing including those from different age groups (both male and female) and encouraging the commitment to lifelong learning of those already engaged in nursing.

(2) It is expected that the Review will consider the following wider issues from the perspective of both the health industry and education:

(a) the changing context of nursing and health requirements and the levers influencing these changes; and
(b) the links between nursing, medicine and other groups in the health workforce (including those with no health qualifications) in the provision of health services.

(3) In carrying out its work, the Review will have regard to:

(a) regional needs and circumstances
(b) financing arrangements, and
(c) the work of current research projects and reviews such as the New Zealand review of nursing education, the Australian Health Workforce Advisory Committee nursing workforce review, and the British review of funding for nursing.

Reference Group

The following organisations were invited to nominate a representative to the Reference Group to the National Review of Nursing Education:

- Australian Council of Deans of Nursing
- Association of Australian Rural Nurses
- The Council of Remote Area Nurses of Australia Incorporated
- Congress of Aboriginal and Torres Strait Islander Nurses
- Royal College of Nursing Australia
- Australian Health Ministers' Advisory Council (2 nominees)
- Australian Private Hospitals Association
- TAFE Directors Australia
- Youth Round Table
- Australian Vice Chancellors Committee
- Group of Eight
- Australian Nursing Council Incorporated
- Australian Local Government Association
- Catholic Health Australia
- Aged and Community Services Australia
- Department of Veterans Affairs
- National Rural Health Alliance
- Australian Nursing Federation
- Australian Nursing Homes and Extended Care Association
- Australian & New Zealand College of Mental Health Nurses Incorporated
- Australian Healthcare Association
- Consumer Health Forum
- Australian Technology Network
Appendix B
Meetings with government departments, organisations and groups

National groups
- Australian Council of Deans of Nursing (2 meetings)
- Australian Nursing Council Incorporated (2 meetings)
- Royal College of Nursing (2 meetings)
- National Nursing Organisations of Australia
- Australian Nursing Federation, National Office (2 meetings)
- Committee of Presidents of Medical Colleges
- Committee of Deans of Australasian Medical Schools
- Australian Vice Chancellors' Committee—Standing
- Committee on Education and Students
- Enterprise and Career Education Foundation (ECEF)
- Uniting Care Australia
- Women's Hospitals Australasia and Children's Hospitals Australasia
- Community Services & Health Training Australia

Consumers
- Combined Pensioners and Superannuants
- Council on the Ageing (COTA)
- Alzheimer's Association
- National Council of Social Services (NCOSS)
- Older Women's Network

Australian Capital Territory
- The Canberra Hospital
- School of Nursing, Canberra University (with representatives from Calvary Hospital, The Canberra Hospital, John James Memorial Hospital and Southern Area Health Service)
- Nursing Board of the Australian Capital Territory (2 meetings)
- Australian Capital Territory Health (2 meetings)
- Australian Capital Territory Department of Education and Community Services
- Open public consultation meetings
New South Wales

New South Wales Health
Nurses' Registration Board of New South Wales (2 meetings)
School of Clinical Sciences, Charles Sturt University, Wagga-Wagga
New South Wales Nursing Association (2 meetings)
New South Wales College of Nursing
Sydney Institute of TAFE
Faculty of Nursing, Midwifery and Health, University of Technology, Sydney
Faculty of Health and Behavioural Sciences, University of Wollongong
Illawarra Institute of TAFE
MedTV Pty Ltd
NSW Department of Education and Training
Open public consultation meetings

Northern Territory

Royal Darwin Hospital
Northern Territory University
Nurses' Board of the Northern Territory (2 meetings)
Northern Territory Health Services (2 meetings)
Department of Employment, Education and Training
Alice Springs Hospital
Open public consultation meetings

Queensland

School of Nursing Sciences, James Cook University, Townsville
Directors of Nursing Association, Queensland
Queensland Nursing Council (2 meetings)
Queensland Nurses' Union (2 meetings)
Moreton Institute of TAFE
Griffith University
Queensland Health
Education Queensland
Department of Employment and Training
Open public consultation meetings
South Australia

Department of Health Services (2 meetings)
Nurses Board of South Australia (2 meetings)
Australian Nursing Federation, South Australia (2 meetings)
University of South Australia, Whyalla Campus
Whyalla Hospital
School of Nursing, Flinders University
Douglas Mawson Institute of TAFE
Nursing Agency of South Australia
Department of Education, Training and Employment
Open public consultation meetings

Tasmania

Department of Health and Human Services, Tasmania (2 meetings)
Tasmanian Chamber of Commerce and Industry
Tasmanian Private Hospitals Association
Nursing Board of Tasmania (2 meetings)
School of Nursing, University of Tasmania, Launceston
Australian Nursing Federation, Tasmania
Health and Community Services Union
Department of Education
Open public consultation meetings

Victoria

Department of Human Services (2 meetings)
Department of Education and Training
Victorian Nurses Board (2 meetings)
La Trobe University, Bendigo
Chisholm Institute of TAFE
Australian Nursing Federation, Victoria (2 meetings)
Aged and Community Services Australia, National Council of the Ageing, Victoria
Aged Care Association of Victoria
Alzheimer's Association, Victoria
Tender Loving Aged Care (TLC) Pty Ltd
Open public consultation meetings
Western Australia

Health Department of Western Australia (2 meetings)
Nurses Board of Western Australia (2 meetings)
Hollywood Private Hospital
School of Nursing, University of Notre Dame
Australian Nursing Federation, Western Australia Branch (2 meetings)
Combined Universities Centre for Rural Health, Geraldton
Chamber of Commerce and Industry
Department of Education Services
Department of Training and Employment
Higher Education
Open public consultation meetings
Appendix C
List of submissions

1. Open Learning Australia
2. Ms Trish Warwarek
3. Mr Glen Ross
4. Director of Nursing and nursing staff, Albany Regional Hospital
5. Dr Karen Francis
6. Emeritus Professor Solomon Posen
7. Ms Bennie Bish
8. Ms Beverley Wright
9. Mr David Huggonson
10. Ms Pat Prozie
11. Mr David Tagliaferri
12. Ms Jayne Eames
13. Professor Heather Gibb
14. Country Women's Association of New South Wales
15. Ms Anne Handley
16. Ms Jigi Lucas
17. Council of Remote Area Nurses of Australia Inc.
18. Nurses Board of South Australia
19. Nurse Educators at TAFE New South Wales North Coast Institute
20. Institute of Nursing Executives New South Wales & Australian Capital Territory
21. Mrs Renate Cowan
22. Queensland Country Women's Association
23. Nurses Registration Board of New South Wales
24. School of Nursing, College of Health, Notre Dame University
25. Reference Group, Nursing Division, Cabrini Hospital
26. The Country Women's Association of Australia
27. Nurses Board of Australian Capital Territory
28. Nursing Staff of Royal North Shore Hospital
29. Ms Carolina Weller
30. Mrs June Cameron
31. Ms Allison Patchett
32. School of Nursing, Faculty of Nursing and Health, Griffith University
33. The South Australian Country Women's Association Incorporated
34. Bendigo Health Care Group
35. Mr David Lee
36. School of Nursing & Midwifery, La Trobe University
37. Ms Loretta Hegarty
38. Ms Margaret Buchanan
39. Ms Caroline Clemens
40. Queensland Nurses' Union
41. Mrs V. O'Keefe
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42. Australian Nursing Federation (Tasmanian Branch)
43. Australian Council of Community Nursing Services Inc.
44. Ms Anne Ferguson
45. Health & Community Services Union (Tasmanian Branch)
46. Ms Sandra Lindley
47. Nurses Board of Western Australia
48. Department of Nursing, University of Southern Queensland
49. Nursing Executive, Sir Charles Gairdner Hospital
50. Australian Catholic University
51. Australian Neonatal Nurses Association
52. Med TV Australia Pty Ltd
53. Joint Submission: James Cook University Townsville Queensland & University of Melbourne
54. Professor Heather Gibb & Ms Irene Jones
55. Aged Care Association of Victoria
56. Ms Helen Forbes
57. Association of Australian Rural Nurses
58. Resthaven Incorporated
59. Charles Sturt University
60. School of Nursing, Avondale College
61. Ms Amanda Williams & Ms Bronwyn Beadle
62. Australian Confederation of Paediatric and Child Health Nurses
63. School of Nursing, Queensland University of Technology
64. Nurses of East Gippsland
65. Australian Nursing Homes & Extended Care Association South Australia Inc. (ANHECA SA Inc)
66. Australian Faith Community Nurses Association Inc.
67. Queensland Nursing Council
68. Ms Lyn McBain
69. Ms Andrea Driscoll
70. Dr Caroline Homer
71. Royal Society for the Welfare of Mothers & Babies (Tresillian Family Care Centres)
72. Australian Council of Deans of Nursing
73. School of Nursing & Midwifery, University of South Australia
74. Nurse & Clinical Nurse Educators, Nursing Development Unit, Education Centre, Central Coast Health
75. Northern Territory Health Services
76. Florence Nightingale Society of Tasmania
77. Ms Margaret Robertson
78. Mr Michael Scott
79. Uniting Care Australia
80. Peninsula Health
81. Nursing Staff, Belmont Private Hospital
82. TAFE New South Wales
83. Adjunct Professor Kathy Baker
84. Faculty of Health & Behavioural Sciences, University of Wollongong
85. Ms Christine M. Giles
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<td>Emeritus Professor J.P. Martin</td>
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<td>Aboriginal Medical Services Alliance, Northern Territory (AMSANT)</td>
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<td>Ms Agnes Misztal</td>
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Appendix D
Research forum

The Review conducted a Research Forum to consider the reports of research projects commissioned for the Review. The Forum was held at The Brassey of Canberra on 3 and 4 October 2001.

Review Panel

Mrs Patricia Heath
Ms Susan Macri
Professor Robin Watts
Ms Ella Lowe
Professor Chris Selby Smith
Mr John Ramsay
(Ms Jenny Duncan was overseas at the time of the Forum)

Invited researchers

Dr Leanne Aitken
Ms Robyn Aitken
Ms Elizabeth Bethune
Associate Professor Scott Bowman
Ms Pat Brodie
Dr Diane Brown
Dr Tracey Bucknall
Professor Judith Clare
Professor Mary Chiandilla (unable to attend)
Professor Jackie Crisp
Ms Stephanie du Boulay
Professor Christine Duffield
Professor Maurice Eisenbruch
Dr Karen Francis
Ms Terri Gibson
Associate Professor Mike Hazelton
Ms Marie Heartfield
Dr Jacqueline Jones
Ms Nicky Leap
Mr Michael Long
Ms Lisa McKenna
Professor Sharon McKinley
Professor Margaret McMillan
Ms Sue North
Professor Pauline Nugent
Ms Robyn Ogle
Professor Alan Pearson
Dr Kay Price
Dr David Saltmarsh
Dr Chandra Shah
Dr Antonia Van Loon
Ms Arlene Walker
Professor Jill White

Facilitator
Emeritus Professor Stephen Kemmis, Director, Stephen Kemmis Research & Consulting Pty Ltd.

Members of the Review Secretariat Attending
Dr Elizabeth McDonald
Ms Dianne McKenna Hantas
Ms Melanie Coates
Ms Natasha Wade
Ms Yolande Peuker
Assisted by Ms Lindon Chapman
Appendix E
Commissioned research

- Literature Review: Mental Health Nursing Education and the Health Labour Force
  Professor Michael Clinton, Ms Stephanie du Boulay, Associate Professor Michael Hazelton and Ms Barbara Horner, University of Newcastle and Curtin University of Technology, 2001

- Midwifery Education: Literature Review and Additional Material
  Ms Nicky Leap and Professor Lesley Barclay, University of Technology Sydney, 2001

  Professor Alan Pearson, Professor Rhonda Nay, Ms Susan Koch, Ms Catherine Ward, Ms Catherine Andrews and Mr Andrew Tucker, La Trobe University, 2001

- Literature Review: Knowledge and skills required to meet the challenges of the changing workforce in the 21st century
  Dr Karen Francis, Associate Professor Scott Bowman and Mr Michael Redgrave, Charles Sturt University, 2001

- Models of Nursing Education and Training: A Systematic Review of the Literature
  Professor Sharon McKinley, Dr Leanne Aitkin, Dr Gordon Doig and Ms Jin Zhu Liu, Royal North Shore Hospital, 2001

- Aspects of Nursing Education: The Types of Skills and Knowledge Required to Meet the Changing Needs of the Labour Force Involved in Nursing
  Ms Robyn L. Aitken, Ms Robyn Faulkner, Dr Tracy Bucknall and Professor Judith Parker, Victorian Centre for Nursing Practice Research, School of Postgraduate Nursing, University of Melbourne, 2001

- Student Expectations of Nursing Education
  Dr. David Saltmarsh, Ms Sue North and Mr Tony Koop, Macquarie University, 2001

- Review of Nurse Regulation
  Professor Mary Chiarelli, University of Technology, Sydney, 2001

- Standards for Nursing Care and the Relationship between Skill Mix and Patient Outcomes
  Professor Jackie Crisp, University of Technology, Sydney, 2001
The Scope of Nursing Practice: The Implication for Contemporary Nursing Education and Practice
Professor Margaret McMillan, Ms Jane Conway, Associate Professor Penny Little and Ms Elizabeth Bujack, University Newcastle, 2001

The Scope of Nursing in Australia: A Snapshot of the Challenges and Skills Needed
Dr Jacqueline Jones and Professor Julianne Cheek, Centre for Research into Nursing & Health Care, University of South Australia, 2001

Enrolled Nurse Education
Ms Lisa McKenna, Dr Robert Sadler, Mr Michael Long and Mr Gerald Burke, Centre for the Economics of Education & Training (CEET), Monash University, 2001

Job Growth and Replacement in Nursing Occupations
Dr Chandra Shah and Mr Gerald Burke, Centre for the Economics of Education & Training (CEET), Monash University, 2001

Nursing Career Pathways Project
Dr Kay Price, Ms Marie Heartfield and Ms Terri Gibson, Centre for Research into Nursing and Health Care, University of South Australia, 2001

Multicultural Nursing Education: Research Paper
Professor Maurice Eisenbruch, Professor Arie Rotem, Ms Donna Waters, Ms Rosemary Snodgrass and Professor Reta Creegan, University of New South Wales, 2001

Development and Analysis of a Hospital Survey Instrument
Professor Christine Duffield, Professor Judith Donoghue, Dr Margaret Uyeda, Dr Jan Forbes and Ms Susanne Mitton-Lewis, Centre for Health Services Management, University of Technology, Sydney, 2001

National Study of Nursing Education: Nursing Education and Graduates, Stage 1
Ms Kaye Ogle, Ms Elizabeth Bethune, Associate Professor Pauline Nugent and Ms Arlene Walker, Deakin University, 2001

National Study of Nursing Education: Nursing Education and Graduates, Stage 2
Ms Kaye Ogle, Ms Elizabeth Bethune, Associate Professor Pauline Nugent and Ms Arlene Walker, Deakin University, 2002

The Nursing Workforce 2010
Dr Tom Karmel and Dr Jianke Li, Department of Education Science and Training, 2002.

Higher Education Statistics for Nursing Students
Department of Education Science and Training, 2002

An Overview of Issues in Nursing Education
Emeritus Professor Richard Johnson and Ms Barbara Preston, 2001
Appendix F

Review secretariat and other support

Secretariat

Elizabeth McDonald, Director, Commonwealth Department of Education, Science and Training
Melanie Coates Commonwealth Department of Education, Science and Training
Dianne McKenna Hantas Commonwealth Department of Health and Ageing
Yolande Peuker Commonwealth Department of Education, Science and Training
Shane Samuelson Commonwealth Department of Education, Science and Training
Natasha Wade Commonwealth Department of Health and Ageing

Other support to the Review

Emeritus Professor Stephen Kemmis facilitator of the Research Forum in Canberra on 3 and 4 October 2001 and provided advice and assistance in drafting the Discussion Paper for the Review
Ms Merran Dawson facilitator of the meetings held in Canberra on 3-5 April 2002 (including the meeting with the Reference Group on 4 April 2002), and in Melbourne on 6-9 May 2002
Ms Penny Rogers provided health policy expertise and writing support for the report
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These are some examples of how phrases can be extracted from the text:
- Sustainable workforce
- Sustainable health care
- Sustainable economic development
- Tertiary Education Rank (TER)
- Technical competency
- Telehealth
- Telemedicine
- TAFE Directors Australia
- TAFE Institutes
- Health and Human Services, Department of Tasmania
- Teaching Hospitals Grants
- Adult entry
- Nursing undergraduates
- Nursing workforce