

Australian Catholic University

Educating the Nurse of the Future

**Submission to the Independent Review
of Nursing Education**

28 June 2019

Submission to the independent review of nursing education, *Educating the Nurse of the Future*

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Executive Summary

Australian Catholic University (ACU) is pleased to respond to the independent review of nursing education in Australia entitled *Educating the Nurse of the Future* (the Review).

ACU is well qualified to comment on the challenges and opportunities facing the education of future nurses.

Nurse education is a core activity for ACU, dating back to the university's forerunner religious orders that prepared teachers and nurses for Catholic schools and hospitals. Today, ACU enrolls the largest number of undergraduate nursing students in Australia,¹ and nurse education remains one of the university's key strengths.

ACU's Faculty of Health Sciences (the Faculty) spends approximately \$15 million each year organising clinical placements for approximately 8,000 nursing and midwifery students, an activity that employs 34 staff and consumes approximately 15 per cent of the Faculty's entire budget. In the three years from 2016 to 2018, the Faculty's clinical placement costs increased by 32 per cent, even though its nursing and midwifery enrolments increased by only 1½ per cent.

From this experience and perspective, ACU makes the following observations about the education of Australia's future nurses:

- Clinical placements are an essential element of the preparation of nurses for the workforce. However, there are not enough clinical placements for student nurses and, increasingly, they are too costly.
- Simulation learning for nurses should be recognised, and regulated, by accreditation bodies.
- Transition to practice programs (TPPs) for new graduates should be governed by consistent standards and should be overseen by universities, where there is better regulation and coverage, rather than by employers.
- The suggestion made at the consultation workshops for a mandatory universal exam for entry into university study should be rejected outright.
 - Universities are best-placed to determine admission criteria for their own institutions and proposals that compromise this institutional autonomy should be resisted.
 - A one-size-fits-all entry exam disregards the academic and personal growth experienced by a student during three years at university.
 - Any effort to restrict the supply of nurses at a time of increasing demand for nurses is a recipe for a skills shortage and higher workforce costs.
- Data about the current nursing workforce is inadequate and should be improved through a reconstituted Health Workforce Australia (HWA) dedicated to this purpose.
- Registered nurses (RNs) should be better rewarded to supervise student nurses.
- The nurse practitioner (NP) who sits at the top of the nursing hierarchy in Australia is underutilised because of their overly-specialised focus.
- Any attempt to make nursing more appealing to men should highlight a nurse's professional functions rather than female nurturing values and thus be made more gender neutral.

¹ Department of Education and Training, *2017 Higher Education Data Collection – Students, Special Courses*. Section 8, table 8.3

Recommendations

ACU makes the following recommendations in response to the Review's four terms of reference (TORs).

From ACU's perspective, the fifth recommendation – on the cost and availability of clinical placements – is the most pressing in respect of the education of the next generation of Australia's nurses.

TOR 1: The effectiveness of current educational preparation of and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery.

Recommendation 1

HWA should be reconstituted by the Federal Government and given the task of providing accurate and current nurse workforce statistics and projections.

Recommendation 2

- a) The Nurses and Midwives Board of Australia (NMBA) should require NPs to have a multi-specialist training focus.
- b) NP training should be open to less experienced applicants in their second or third year of nursing.

Recommendation 3

- a) The Review should reject outright a pre-entrance exam for RNs prior to university.
- b) The value of any post-graduation exam as a condition of registration, over and above the completion of university-administered assessment, should also be considered critically, including with reference to the costs of its administration.

Recommendation 4

A reconstituted HWA should investigate the number and range of clinical placement hours required of RNs and whether the Australian Nursing and Midwifery Accreditation Council (ANMAC) requirement of 800 hours is appropriate.

Recommendation 5

A reconstituted HWA should conduct an independent, evidence-based analysis of clinical placement availability and costs that includes:

- a) a recommendation as to the share of clinical training costs that should be passed on to universities, represented as a nationally consistent dollar amount per day;
- b) a published benchmark number of clinical placement hours that a health service should provide (based, potentially, on the number of full-time equivalent nurses employed or the amount of public funding received); and

- c) a requirement, in the interests of promoting transparency, for each health provider to publicly report to HWA the number of clinical placement hours it has provided in the past year so as to:
- i. identify which health providers are doing the “heavy lifting” in relation to the training of Australia’s next generation of nurses; and
 - ii. encourage the greater provision of clinical placements to nursing students.

This independent process should ideally be conducted periodically, with an indexation mechanism applying to benchmarks in between each review.

Recommendation 6

The NMBA should recognise and clarify the clinical facilitator’s role and provide incentives for more senior RNs to mentor and teach student nurses via:

- a) credentials that are recognised by employers; or
- b) incentives such as credit towards postgraduate study.

Recommendation 7

ANMAC should recognise simulation learning as a significant component of the clinical placement requirement for nurses and regulate its quality.

TOR 2: Factors that affect the choice of nursing as an occupation, including for men.

Recommendation 8

Adopt a gender-neutral approach to raise the status and appeal of nursing by emphasising its professional functions rather than its nurturing values.

TOR 3: The role and appropriateness of transition to practice programs however named.

Recommendation 9

Nursing degrees should become four years in duration, with the new fourth year effectively taking on the role and function of the existing TPP.

TOR 4: The competitiveness and attractiveness of Australian nursing qualifications across international contexts.

No recommendation.

Context

There is a crucial paucity of data about Australia's nursing workforce.

Projections for the nursing workforce were last made by HWA in 2014 (before that Federal agency was dissolved) but a current workforce assessment was undertaken in 2017 by the Commonwealth Department of Health (the Department), which form the latest nursing workforce statistics.

The four main types of Australian nurses (including midwives) and the formal qualifications that distinguish them are outlined in Table 1 and Table 2 below:

Table 1: Number and type of accredited nurses in Australia, 2014-2017

	Formal qualifications required	2014	% of total	2017	% of total	14-17 change
Enrolled Nurse (EN)	A Diploma of Nursing delivered through the VET sector (typically 18 months)	58,353	15.4%	60,146	15.0%	3.1%
Registered Nurse (RN)	A 3-year Bachelor of Nursing delivered through a university	286,856	75.9%	309,489	77.1%	7.9%
Midwife (MW)	A 3-year Bachelor of Midwifery <u>or</u> a Bachelor of Nursing & Graduate Diploma / Master of Midwifery	31,457	8.3%	30,070	7.5%	-4.4%
Nurse Practitioner (NP)	A RN experienced in their clinical specialty but educated at Masters Level and endorsed by the NMBA to provide patient care in an advanced and extended clinical role.	1,085	0.3%	1,556	0.4%	43.4%
TOTAL		377,751		401,261		6.2%

Table 2: Number and type of employed nurses in Australia, 2014-2017

	2014	% of total	2017	% of total	14-17 change
EN	50,737	15.6%	51,478	14.8%	1.5%
RN	246,606	75.6%	267,783	77.2%	8.6%
MW	27,773	8.5%	26,369	7.6%	-5.1%
NP	1,036	0.3%	1,462	0.4%	41.1%
TOTAL	326,152		347,092		6.4%

Source: National Health Workforce Data Set (NHWDS), 2017 *Factsheets*, Australian Government Department of Health

According to the Department's data, by far the largest category of nurse is RNs. Their share of the total proportion of nurses grew from approximately 76 to 77 per cent from 2014 to 2017. EN numbers are growing but not as fast as RNs, meaning their share of the total is declining slightly, from 15.5 to 15 per cent. Midwife numbers are declining both in numerical terms and as a share of the total, from 8.3 to 7.5 per

cent. Nurse practitioner (NP) numbers are growing but from a very small base, reflected in their share of the total being less than half a percent, at around 0.3-0.4 per cent.

Despite the varying rates of growth, Australia's demand for nurses will continue to accelerate. According to the 2014 HWA projections, Australia's demand for nurses will significantly exceed supply in the medium to long-term, with a projected shortfall of approximately 85,000 nurses by 2025, and 123,000 nurses by 2030.² This escalating demand is driven by a number of factors (see Table 3):

Table 3: Factors driving future demand for nurses

1. *Population growth*

- A larger population demands more health care and consequently, more nurses. Australia's population is projected to grow at 1.3 percent per year, resulting in a population of almost 40 million in 2054-55.³

2. *Demographic change*

- An ageing population will require a disproportionately higher level of health care due to more complex and chronic health problems, hence more nurses. The number of Australians aged 65 and over is projected to more than double in the 40 years from 2014-15 to 2054-55 and there will be around 40,000 people aged over 100 by 2054-55, which is 300 times the number there was in 1974-75.⁴

3. *Changes in the nature and prevalence of various diseases*

- Chronic health conditions will increase the demand for treatments and consequent care, including more nurses. Chronic disease is already the leading cause of illness, disability and death in Australia.⁵

4. *Technological change and consumer expectations about access to health services*

- The emergence of new, more effective treatments increases the demand for these treatments. Greater demand in general means greater demand for nurses to administer these treatments. Moreover, as incomes rise, so too does the consumption of greater or higher quality health care services, with real health expenditure per person expected to more than double over the next 40 years.⁶

² Health Workforce Australia (HWA). *Australia's Future Health Workforce – Nurses Overview*. (August 2014). The extent of economic growth can influence these future predictions. For example, if Australia experiences lower economic growth in the future, this will slow provision of health services and consequently demand for nurses. But even under this scenario, where Australia experiences economic growth of 2.7% as opposed to the long-run average of 3.3% per annum, the likely shortfall of nurses will still be approximately 94,000 by 2030.

³ Australian Government. *2015 Intergenerational Report: Australia in 2055*. (March 2015)

⁴ *ibid*

⁵ These being cardiovascular diseases, oral health, mental disorders, and musculoskeletal. Australian Government. *Reform of the Federation White Paper, Issues Paper 3: Roles and Responsibilities in Health*. (Dec 2014)

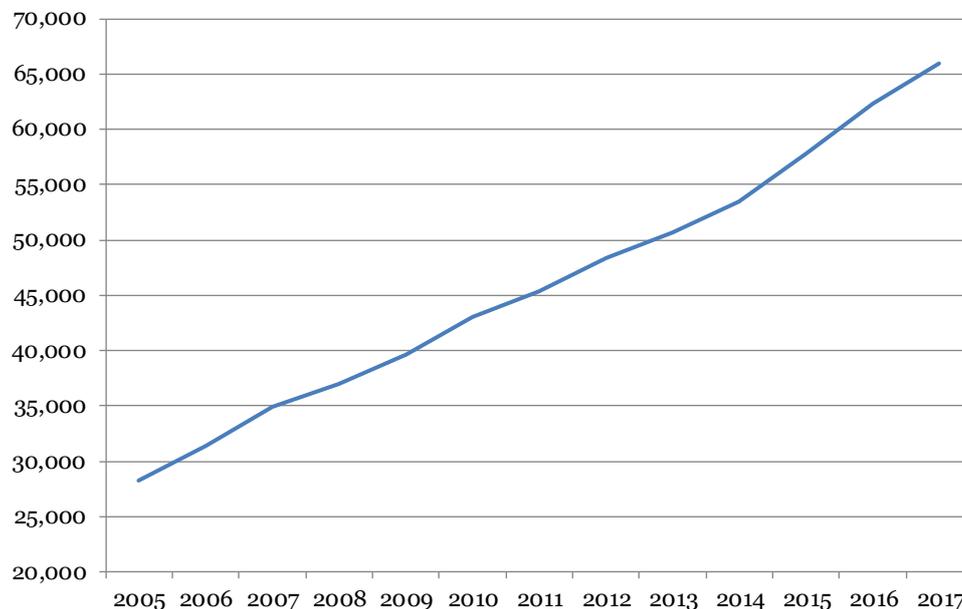
⁶ Australian Government. *2015 Intergenerational Report: Australia in 2055*. (March 2015)

5. Fewer hours worked by individual health care workers

- More health care workers are needed in total as more individual health care workers seek to work fewer hours. Many nurses, doctors and other health professionals are working fewer hours, partly for work-life balance but also due to the rising intensity of care required for patients. Nursing is increasingly becoming a part-time profession, with the average hours worked per week for ENs and RNs being 31-32 hours and for MWs less than 20 hours.⁷

Universities have responded to this increased demand with a 130 per cent growth in national enrolments of those studying to become RNs over the past 12 years (see Figure 1):

Figure 1: All students enrolled in a Bachelor of Nursing, 2005 to 2017



Source: Commonwealth Department of Education and Training, Higher Education Statistics – 2017 Student data, *Section 8: Special Courses*, Table 8.6 (2017 is the latest year available).

Due to its status as a high-quality provider, and in response to student demand, ACU increased its nursing enrolments by over 270 per cent over the same time period, from approximately 1,900 students in 2005 to 7,000 students in 2017.⁸

However, there is evidence that supply more broadly is not keeping up with demand.

There is a growing use of unregulated nursing workers instead of RNs and ENs, particularly in the community and aged care settings. These nursing assistants (also called patient care assistants or personal care attendants) have progressed from making beds and helping patients feel comfortable to taking blood pressure and blood glucose levels, dressing wounds and, in some cases, performing venipuncture (puncturing a vein to take blood).⁹

⁷ National Health Workforce Data Set (NHWDS), *2017 Factsheets*, Australian Government Department of Health.

⁸ Internal ACU data.

⁹ Duffield, Christine. 'Replacing registered nurses isn't the answer to rising health costs.' *The Conversation*, April 24, 2014.

National and international research has found that decreasing the hours of care provided by RNs and ENs through substitution with assistants results in poorer patient outcomes and can increase the risk of complications and even death.¹⁰ The Aged Care Royal Commission currently underway in Australia will likely find further shortfalls in the training and qualifications of aged care staff.

Such short-sighted strategies to replace qualified nurses with assistants reflect cost-saving imperatives but also shortages of qualified staff. This shortfall is already pronounced in mental health and particularly the aged care sector. Older nurses are already working in aged care while, increasingly, fewer nurses are choosing to work in this sector.¹¹ There is lower remuneration for qualified nurses in the sector¹² and aged care has trouble attracting nurses who, like doctors, often do not want to work at the end of life.

In summary, the broader context for this submission is that:

- a) there is a growing demand for nurses;
- b) the likely shortage of qualified nursing staff is already being felt in some areas; and
- c) there is an overriding necessity to ensure that there is current and robust data about the evolving state of the nursing workforce in Australia.

Recommendation 1:

Health Workforce Australia (HWA) should be reconstituted by the Federal Government and given the task of providing accurate and current nurse workforce statistics and projections.

¹⁰ *ibid.* See also Twigg, D. E., et al. (2010). 'The impact of nurses on patient morbidity and mortality - the need for a policy change in response to the nursing shortage.' *Australian Health Review*, 34(3), 312 -316.

¹¹ Health Workforce Australia (HWA). *Australia's Health Workforce Series – Nurses in Focus*. (2013).

¹² *ibid.*

Term of Reference 1

The effectiveness of current educational preparation of and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery

Articulation

ENs to RNs

Generally, articulation works well between the training of ENs in Vocational Education and Training (VET) and the training of RNs at universities.

ENs wishing to transfer to become an RN can enter the second year of a Bachelor of Nursing after 18 months successful completion of their EN qualification at an ANMAC-accredited VET provider.

The Department's data, set out above, shows only a very small increase in the number of ENs employed from 2014 to 2017 (see Table 1 on page 6). This is despite strong demand for ENs amongst public and private providers due to their lower cost. Anecdotal evidence suggests hospitals want to increase the share of ENs as a proportion of their total workforce from a current level of 10 per cent to 40 per cent.

While more ENs may create a more affordable workforce, they do not necessarily create a better workforce. In fact, the employment of less qualified staff may be more expensive for health providers in the long run. For example, RNs trained in the inspection, assessment and early treatment of pressure area sores (bed sores) will reduce long-term costs to health providers by detecting this condition more quickly than less-qualified staff, who are likely to take longer to identify such issues.

Ensuring higher quality care should be the central goal of nursing policy and, to that end, greater articulation of ENs to RNs should be encouraged. The barriers that prevent ENs from becoming RNs should be removed wherever possible.

For example, one anxiety amongst some ENs is that they will risk losing their substantive position as an EN once they undertake full-time study to become an RN. Policies that entrench a "right of return" to employment for such nurses may help alleviate this concern.

RNs to NPs

While, in general, the articulation of ENs to RNs is common, there is a practical barrier to the articulation of RNs to NPs. NPs are commonly considered too expensive by Australian health care providers and, as such, there is an unfortunate aversion to employing NPs in the Australian setting.

In the United States, NPs began in the 1960s in response to widespread shortages and an uneven distribution of physicians and they now play important roles in many health care fields, especially in primary care.¹³ In 2019, there were more than 270,000 NPs licensed in the US, 87 per cent of them certified in an area of primary care, 96 per cent of them prescribing medications. NPs in the US have a mean, full-time base salary of \$US105,903.¹⁴

¹³ Agency for Healthcare Research and Quality, (2010), "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States."

¹⁴ American Association of Nurse Practitioners, (2019), "NP Facts."

In Australia there were only 1,500 registered NPs in 2017 (see Table 1). Although Australian NPs can also prescribe medications and order and interpret tests, NPs are routinely underutilised in Australia.¹⁵ This has led to a cultural unfamiliarity with the role of NPs.

The NP positions that do exist in Australia are largely located in hospitals – such as in emergency departments, renal dialysis units, psychiatry units, etc – rather than in primary health care. In other words, most NPs are employed by state and territory governments in acute care settings, despite health provision increasingly moving to primary (non-hospital) care.¹⁶

There is also role uncertainty between NPs and General Practitioners (GPs). The sensitivities involved can be seen in the Royal Australian College of General Practitioners (RACGP) official position that it does not support NPs working autonomously in the primary healthcare sector, only within GP-led general practice teams.¹⁷

This position is reflected in NPs only obtaining a Medicare provider number if they work in collaborative arrangements with a medical practitioner.¹⁸ It is partly because of this ruling that most NPs work in public hospitals where the cost of their service is covered as part of the patient's admission.

A broadening of NPs' access to Medicare provider numbers may be warranted to relieve the patient burden on doctors in regional and rural areas and to recognise that, in general, most NPs do not want to work in isolation from GPs.

Effective health care depends on effective collaboration. NPs generally welcome working alongside, and under the direction of, GPs. NPs will not supplant GPs or work in isolation from them but rather could be deployed to make the overall health care system more efficient and effective, particularly where there is high demand for limited health services.

Aside from the restrictions to Medicare provider numbers, the training of NPs is too specialised. For example, an Australian NP will not simply be a nurse who specialises in overall paediatric care; they will be a specialist in paediatric cardiac care. This contrasts with the US where NPs occupy a more generalist role and are familiar, for example, with the multiple disciplines of paediatric care.

Often, NP positions are only open to nurses who have practiced for many years in specific sub-specialities, further entrenching the highly specialised nature of the NP role.¹⁹

A broader knowledge base should be pursued in the training and selection of NPs, while observing that the balance between generalist or specialist NPs is not an “all or nothing” proposition. NPs will always need specialist training, but it is a matter of degree, with specialisation taken too far in the Australian context and unnecessarily limiting the usefulness of these highly qualified staff.

If NPs are to assist a broader range of patients, and their expertise used more widely, they should occupy a multi-specialist role as occurs in the US. A broadening of their narrow specialisation focus will help NPs diagnose, treat and manage more patients and deliver more creative models of care.

¹⁵ Stacy Leidel (21 Nov 2013), “Australia could do so much more with its nurse practitioners,” *The Conversation*.

¹⁶ Australian Government Department of Health, <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac>

¹⁷ RACGP (2016), “Nurse practitioners in primary healthcare: Position Statement, August 2016.”

¹⁸ Department of Health, “Eligible Nurse Practitioners Questions and Answers,”

<https://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda-nursepract#3>

¹⁹ See also Stacy Leidel (2013), “Australia could do so much more with its nurse practitioners,” *The Conversation*, 21 November 2013

In the meantime, without better definition and utilisation of the role of NPs, and with few NP jobs available for graduates, there is little incentive for universities to offer courses that articulate RNs to become NPs.

Recommendation 2:

- a) The Nurses and Midwives Board of Australia (NMBA) should require NPs to have a multi-specialist training focus.
- b) NP training should be open to less experienced applicants in their second or third year of nursing.

RN registration

Professor Schwartz raised a proposal during the consultation workshops that all RNs should sit and pass a standardised exam prior to registration, similar to the Literacy and Numeracy Test for Initial Teacher Education (LANTITE), which all teachers must now pass before teacher registration. A suggestion from the floor went further than this, suggesting that such a test should be a mandatory hurdle to even entering a university nursing course.

The proposal from the floor for a pre-entrance exam for nurses should be rejected for the following reasons:

- 1) It seriously compromises universities' autonomy, as self-accrediting institutions, over their respective admission processes.
- 2) It disregards individual students' capacity for academic and personal growth over the course of a three-year university degree, effectively assuming that their knowledge and ability is static.
- 3) It would restrict diversity in the nursing profession by disproportionately excluding nurses from regional, disadvantaged, lower socio-economic status and indigenous backgrounds who may not pass a pre-entrance exam straight from school but may do so after university.
- 4) Placing additional hurdles to entry into nursing degrees will have a deterrent effect on students choosing between various courses or disciplines at the very time that demand for additional qualified nurses is increasing.

With respect, Professor Schwartz's suggestion of an exam at the end of a nursing degree prior to registration is also flawed, albeit for different reasons.

Such an exam overlooks the value and credibility of university assessment undertaken over the course of a nursing degree, instead placing undue weight (and student pressure) on a single piece of assessment. It would impose an additional burden – including in terms of its cost to administer – without any demonstrated need or evidentiary basis.

Recommendation 3:

- a) The Review should reject outright a pre-entrance exam for RNs prior to university.
- b) The value of any post-graduation exam as a condition of registration, over and above the completion of university-administered assessment, should also be considered critically, including with reference to the costs of its administration.

Preparation

Clinical training of RNs at university

The most significant and pressing issue in the preparation of Australia's future nursing workforce is the shortage of quality clinical training placements for RNs whilst at university.

Given the strong evidence that more nurses will be needed in the future, ACU submits there is need for a more cost-effective and rational approach.

The cost burden on universities for clinical placements has been steadily increasing. For example, in the three years from 2016 to 2018, clinical placement costs for ACU's nursing and midwifery students increased by 32 per cent, even though our nursing and midwifery enrolments increased by only 1½ per cent.

Part of the problem is that private health providers have no limitations on the amount they charge universities for supervision, yet universities must utilise private providers to create enough placements. There is already immense competition between higher education providers as they vie to get the placements they need. It is understood one university was looking at child care centres as a venue for clinical placements for nursing students due to the lack of any other options. Some private health providers have seen this demand as a way to make money where, as at an auction, placements are offered and provided to the highest bidder. There is no national benchmark of cost that private providers must abide by, even though these private providers receive public funds to operate.

How much clinical training is necessary?

Section 3.6 of ANMAC's Accreditation Standards for Registered Nurses (2012) requires "a minimum of 800 hours of workplace experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health-care settings".²⁰

This requirement is strictly enforced. If a student misses some of their scheduled workplace experience hours, whether due to illness or some other reason, they must complete them at another time, even if they have completed all other course requirements.

Students demonstrate knowledge, skills and overall competence in nursing at different rates. Some students require more hours of workplace experience to demonstrate competence, and some less.

An independent body such as HWA should investigate the appropriate number of hours of clinical experience required for RNs. Currently, ANMAC rigidly enforces its 800-hour requirement despite there being no evidence to support it, nor is there any uniformity in its application (e.g. some universities offer 1,000 hours of clinical placements).

Recommendation 4:

A reconstituted HWA should investigate the number and range of clinical placement hours required of RNs and whether the Australian Nursing and Midwifery Accreditation Council (ANMAC) requirement of 800 hours is appropriate.

²⁰ Australian Nursing and Midwifery Accreditation Council (ANMAC). *Registered Nurse Accreditation Standards 2012*. (October 2012).

Limited availability and increased cost

The growing and highly variable costs of clinical placements and their limited availability is threatening Australia's future nursing workforce.

There have been profound changes to health service delivery in Australia not matched in the training of nurses. Since the 1990s, Australia has shifted to more decentralised, multidisciplinary care of patients in local communities.²¹ This shift has been driven by several factors, including cost, emerging health and information technologies that remove constraints on the way care is delivered, and the nature of diseases that health professionals are treating, with more chronic illnesses and older and disabled patients prevalent in the population.

However, the shift in the structure of health systems has not seen a complementary change in the clinical training of nurses, which is still largely operating under an apprenticeship model focused on public hospitals, where three-quarters of health training hours occur in public health services.²² The shift to primary and community based care and to private provision should be matched by an increase in clinical placements for nurses in these private settings. Yet national figures show that the proportion of training provided by the private sector declined between 2011 and 2012 (the latest data available),²³ and anecdotal evidence suggests this trend is continuing.

While the public and not-for-profit sectors provide much of the clinical training for nursing students, many graduates end up working for private providers. More placements in private, community based, and preventative health care locations would expand the supply of placements and ensure students' experience at university matches the real practice settings where they are likely to be working. At present, many students end up working for private providers and in community primary care health settings but never have trained in those settings. A more coherent system would broaden clinical training to better reflect where more health workers will work.

Some health providers, particularly small providers, offer many reasons for not providing placements, such as the costs not being built into their business model, or administration support not being readily available, etc. There are undoubtedly costs involved but there are also benefits:²⁴

- Cheap and productive labour is the most tangible benefit providers obtain from student clinical placements. Students can provide direct clinical services but also indirect services, such as general administrative tasks, waiting lists, patient scheduling, evaluating work processes, etc.
- Employers can identify promising individuals to employ in the future.
- The placement may prompt supervisors to reflect on their own practice from their interaction with students and universities.
- The health provider develops the next generation of health worker, which is the traditional reason for hosting clinical placements; i.e. the provider recognises their field will only continue to develop if they provide hands-on experience to the next generation.

²¹ Australian Government. *Reform of the Federation White Paper, Issues Paper 3: Roles and Responsibilities in Health*. (Dec 2014)

²² Health Workforce Australia (HWA). (2013). *Clinical Training 2012: Survey Results June 2013*. p.9

²³ *ibid*.

²⁴ These benefits are summarised in Buchanan, J., Jenkins, S and Scott, L. (2014) *Student Clinical Education in Australia: A University of Sydney Scoping Study*, The University of Sydney.

However, what was once a collaborative partnership between universities and health providers to train the sector’s future workforce has become a more transactional relationship. Health providers commonly invoice universities on a full cost-recovery basis and sometimes even as a source of profit.

Price gouging for placements and a narrowing of placement types is now a serious problem, with cost variability rife and unsustainable. Universities Australia (UA) has observed that there is little, if any, funding support for student placements outside of public hospitals, yet even public hospitals are attempting to price gouge universities on placements.²⁵

ACU agrees with UA’s assessment that current clinical placement activity for many health disciplines remains mismatched with the skill mix and distribution required for Australia’s future workforce needs.²⁶ In ACU’s experience, nursing remains one of the worst health disciplines for escalating cost and limited availability of placements, as well as the quality of clinical placement available, with significant variability raising real questions about value for money. The serious mismatch in supply and demand for nursing clinical placements creates a short-term risk for universities but a much more profound risk for society by failing to develop and expand the next generation of health workers.

A reconstituted HWA should independently consider the appropriate cost burden that should be shared between providers and universities. Victoria already does this through its “Standardised Schedule of Fees for Clinical Placement of Students in Victorian Public Health Services”, which sets out the maximum chargeable fees for supervision of students.²⁷ This schedule only operates for public providers and only in Victoria. A similar benchmark should operate nationally and cover public and private providers. In addition, benchmarks should be established for training that should be provided by different types of health providers. ACU considers this investigation to be the most important recommendation it makes in this submission.

Recommendation 5:

A reconstituted HWA should conduct an independent, evidence-based analysis of clinical placement availability and costs that includes:

- a) a recommendation as to the share of clinical training costs that should be passed on to universities, represented as a nationally consistent dollar amount per day;
- b) a published benchmark number of clinical placement hours that a health service should provide (based, potentially, on the number of full-time equivalent nurses employed or the amount of public funding received); and
- c) a requirement, in the interests of promoting transparency, for each health provider to publicly report to HWA the number of clinical placement hours it has provided in the past year so as to:
 - i. identify which health providers are doing the “heavy lifting” in relation to the training of Australia’s next generation of nurses; and

²⁵ UA (Jan 2019), *2019–20 Pre-Budget Submission*, p. 19

²⁶ Ibid.

²⁷ This schedule can be found here: <https://www2.health.vic.gov.au/health-workforce/education-and-training/student-placement-partnerships/fee-schedule-for-clinical-placement-in-public-health-services>

- ii. encourage the greater provision of clinical placements to nursing students.

This independent process should ideally be conducted periodically, with an indexation mechanism applying to benchmarks in between each review.

Reforming the role of clinical facilitator

In Australia, the supervision of student nurses is an unrecognised, undervalued burden rather than a core competency in need of development.

The supervision of student nurses is the major cost for nursing placements. A “clinical facilitator” supervises, provides education and assesses approximately eight nursing students at a time. In Victoria, the health service predominantly employs the clinical facilitator (“in-house facilitation”) but in other jurisdictions, the university is required to employ the facilitator on a contract basis, which is more expensive (due to on-costs and added administration) and ineffective because the facilitator may not have a pre-existing relationship with the health setting where the placements will take place. For example, the cost to ACU of providing clinical placements to its nursing students is nearly 40 per cent more for each eight-student training cohort in NSW than it is in Victoria.

One of the main reasons NSW Health resists “in-house” facilitation is their view that it will add to nurses’ already overstretched workloads. The constant refrain from health providers approached by universities is that their staff is stretched to capacity and cannot take on any more load. Even though supervision is part of the ANMAC Competency Standards, there is no incentive for RNs to supervise student nurses and in fact, senior RNs will earn less if they take on this role.²⁸

An opportunity exists to recognise the supervisory aspect of a RNs role via incentives or credentials provided by registration bodies that are recognised and rewarded by employers. This happens in the United Kingdom (U.K.), where facilitators, or mentors as they are called in that country, play a central role in delivering clinical training. In the U.K., the role of mentor is considered an important step in a nurse’s career development and RNs are keen to become mentors to gain promotion in the National Health Service.

This does not occur in Australia, where supervision is relegated to junior RNs who may not even be employed by health services but rather on a casual basis by the university.

There are also no national standards for clinical facilitators in Australia. There is no definition for what the role is or what it entails, or what support is required to maintain competence through relevant knowledge and attributes. ACU has worked hard to establish some kind of structure around the standards, expectations, and proficiency levels expected of the facilitators they employ through online training modules. However, it is difficult to impose and maintain consistent standards on a casual workforce that is also quite large. It also raises the question of whether other universities are re-investing in their clinical facilitators in this way and if not, what the standards are of facilitators across the board.

The job of supervising student nurses, currently undertaken by clinical facilitators, is an unrecognised, undervalued burden rather than a core competency in need of development. Australia needs to clarify the clinical facilitator role through incentives or credentials that make more RNs want to be facilitators.

²⁸ An eighth year RN (who is automatically at the top of the RN pay scale) will receive less as a clinical nurse educator (CNE) than as an eighth year RN, particularly after taking shift work penalties into account. Consequently, inexperienced RNs in their second or third year often take on the role of CNE rather than more experienced RNs.

Recommendation 6:

The NMBA should recognise and clarify the clinical facilitator's role and provide incentives for more senior RNs to mentor and teach student nurses via:

- a) credentials that are recognised by employers; or
- b) incentives such as credit towards postgraduate study.

Simulation

When the last national review of nursing education was conducted in 2002,²⁹ there was no conception that high-quality simulation could be just as effective for student learning as clinical placements. Yet that development has now come to pass. Formal recognition of simulation's role in student learning should now be embedded in accreditation requirements for nursing, as they already have been for occupational therapy and physiotherapy.

The Accreditation Standards for Registered Nurses are currently being revised but the current standards (2012) require a minimum of 800 hours of workplace experience, not inclusive of simulation activities (section 3.6). ANMAC also requires courses of study to prepare students for workplace experience and, "wherever possible, incorporates opportunities for simulated learning" (Section 3.7). In other words, simulation learning is important, but it will not count in any way towards the 800 hours of workplace experience.

This ruling needs to be changed because there is growing evidence that simulation can be just as effective for student learning as clinical placements. From 2009 to 2014, HWA's Clinical Training Fund invested in the use of simulated learning technologies, and that process has continued to accelerate. Simulation learning has always been a feature of nursing training, but advances have progressed to such an extent that the equivalence of simulation-based learning to physical placements is now evident.

For example, a landmark study in the US by the National Council of State Boards of Nursing (NCSBN) found no statistically significant differences in clinical competency between students who had traditional clinical experiences, 25 per cent of their traditional clinical hours replaced by simulation, or 50 per cent of their traditional clinical hours replaced by simulation.³⁰ Further, in the first six months of their working life, no differences were found in manager ratings of overall clinical competency and readiness for practice. The results provide substantial evidence that substituting up to half of traditional clinical hours with high-quality simulation experiences produces "comparable end-of-program educational outcomes and new graduates that are ready for clinical practice."³¹

ACU is not arguing that simulation should become a cost-effective way to absorb increased student demand for placements. Simulation is not cheap when done properly. This form of learning should be seen as a complement rather than a replacement for physical workplace experiences. If simulation is to count towards clinical placement hours, then it should have minimum standards applied to safeguard and ensure its quality.

²⁹ National Review of Nursing Education 2002: our duty of care,

³⁰ Hayden, J.K., et al (2014). "The NCSBN National Simulation Study." *Journal of Nursing Regulation*. Vol 5, Issue 2, July 2014.

³¹ *ibid.*

ACU therefore supports rigorous quality assurance regimes to ensure sufficient standards of simulation learning. But ACU also suggests that ANMAC recognise and regulate simulation's rightful place as a significant component of clinical practice.

Recommendation 7:

ANMAC should recognise simulation learning as a significant component of the clinical placement requirement for nurses and regulate its quality.

Term of Reference 2

Factors that affect the choice of nursing as an occupation, including for men

Caring for people in vulnerable states has historically appealed more to women than to men. Yet there are good reasons to attract more men into nursing, including:

- men bring different skills to the profession;
- men remain an untapped workforce at a time when there is a significant nurse shortage;³²
- half of a nurse’s patients are male and evidence in healthcare settings suggest a degree of affinity with the carer is desirable;³³ and,
- all professions should reflect the broader make-up of society.

Nursing remains a predominantly female occupation, with female representation ranging from nearly 100 per cent for midwives to 80 per cent for nurse practitioners, with the average being about 90 per cent (see Table 4):

Table 4: Nurses by gender in Australia, 2017

Type	Gender	%
EN	Female	90.3
	Male	9.7
RN	Female	88.6
	Male	11.4
MW	Female	98.5
	Male	1.5
NP	Female	80.9
	Male	19.1

Source: NHWDS, 2017 *Factsheets*, Australian Government Department of Health

Some nursing specialisations attract men more than others such as mental health (where 32 per cent of nurses are male), emergency (16 per cent), critical care (14 per cent), management (14 per cent) and policy (12 per cent).³⁴

Research in another female dominated profession, teaching, found that the impact of wage rises tends to attract more women than men.³⁵ This finding is likely applicable to nursing as the incentives that draw men away from the profession are similar.

³² “Nursing - why it needs to attract more men,” *The Age*, June 10, 2003

³³ Haigh, M. (2015). *Men in nursing: a quantitative study from the perspective of West Australian nursing students*. Page 2.

³⁴ Health Workforce Australia (2014), *Australia’s Future Health Workforce – Nurses Detailed*, Figure 6.

³⁵ “A seemingly obvious solution is to increase teachers’ salaries across the board. But this may, in fact, raise the concentration of women in teaching even more. Higher salaries would further increase the returns in teaching relative to other professions for women. But it would have a small or negligible impact on the returns for men”; see Tani, Massimiliano (Jan 2019), “Why are teachers mostly female? Because men get better pay in other professions,” *The Conversation*, 21 January 2019. See also Carroll, David et al (December 2018), “Teaching, Gender and Labour Market Incentives,” IZA Institute of Labor Economics, Discussion Paper Series, p. 20.

Nursing is regularly voted the most highly regarded profession in Australia.³⁶ Yet the social status of a nurse is less than that of a doctor, lawyer, or engineer, largely because of its lower perceived skills level as well as its lower pay.

Given pay increases alone would likely attract more women than men to nursing, a more effective focus would be to emphasise the wide and varied skills level required of nursing. A study on this topic found that one of the greatest single changes that would make nursing a more attractive career choice for men would be to deemphasise female nurturing values and highlight a nurse's professional functions; e.g. the technical, medical, and administrative as well as caring skills required to be a nurse.³⁷

To raise the skill status of nursing generally, rather than specifically for men, the public perception of nursing should move beyond clinical bedside nursing. Expanding and publicising the variety of work that nurses do, whether in education, community support, administration, or clinical practice, and the career opportunities that are available, would expand nursing's appeal. The overall objective should be to increase the skills status of the profession generally by expanding what it means to be a nurse.

Recommendation 8:

Adopt a gender-neutral approach to raise the status and appeal of nursing by emphasising its professional functions rather than its nurturing values.

³⁶ Nurses are first, followed by Doctors and Pharmacists. Roy Morgan Research. *Roy Morgan Image of Professions Survey 2017*

³⁷ M. Haigh's literature review and own study supports this view; see note 33 above

Term of Reference 3

The role and appropriateness of transition to practice programs however named

Transition to practice programs (TPPs) usually occur in public hospitals.

There are currently significant problems with the TPP, including:

- The cost and time pressures imposed on public hospitals. The TPP is meant to bridge the gap between university and the clinical world yet the on-the-job training process is costly, while the effectiveness of the programs that occurs within different hospitals is largely unknown.
- There is no standardised requirement for the number of study days offered or workshops attended or even content conveyed in the different TPPs offered by different hospitals.
- Not all nurses who graduate are offered TPPs. For example, anecdotal evidence suggests only 50 per cent of nursing graduates in Western Australia enter a TPP. International students who graduate from a nursing degree are not offered TPPs at all.

ACU recommends the TPP be undertaken by universities as the fourth year of a nursing degree. There are strong reasons for making this change, including:

- Nursing has until very recently been the only three-year trained health profession in Australia. All other health professions registered by the Australian Health Practitioner Regulation Agency (AHPRA) require a four-year degree.³⁸
- University degrees are accredited by the Tertiary Education Quality and Standards Agency (TEQSA), with nursing requiring additional ANMAC accreditation. The previously unknown activities of the TPP would be clearly regulated and have a far greater consistency in terms of quality control.
- The coverage would be universal. All nurses would complete the program rather than the more variable coverage that currently occurs.

Transferring the TPP to the fourth year of a nursing degree rectifies the wide variability, high cost, low coverage, and unknown relevance of the current structure.

ACU recommends that such a change is justified given:

- a) the current problems with the TPP;
- b) the greater control and consistency that would occur by moving the TPP to universities; and,
- c) the benefits in nursing becoming a four-year degree, giving the profession a greater status both domestically and internationally.

If the change was to occur, then it would become even more vital for clinical placements to be sourced in locations wider than they are currently available. This goes to the importance of ACU's fifth recommendation; namely, that clinical placements be better coordinated and organised at a national level and be increasingly located in private, community based and preventative health care services as well as in public hospitals.

³⁸ This changed in December 2018 when paramedicine, another three-year degree, was recognised by AHPRA.

Recommendation 9:

Nursing degrees should become four years in duration, with the new fourth year effectively taking on the role and function of the existing TPP.

Term of Reference 4

The competitiveness and attractiveness of Australian nursing qualifications across international contexts.

The Australian Nursing Bachelor's degree is recognised overseas and to ACU's knowledge no graduate who has applied for registration to practice in another country has had their degree rejected.

In the three years from 2016 to 2018, ACU received approximately 150 requests (50 per year on average) for copies of students' academic transcripts to be provided to overseas employers and registration authorities, most commonly in the US and the U.K. During that time, there was not one instance of ACU credentials not being recognised overseas.

Australian nursing qualifications are not entirely consistent with overseas requirements. For example, nursing is a three-year degree in Australia while in the US it is a four-year degree. Yet in ACU's experience, nurses trained in Australia, particularly at ACU, are highly sought after in international contexts. Therefore, ACU has no recommendation to make regarding this TOR.

ATTACHMENT A: Australian Catholic University profile

Australian Catholic University (ACU) is a publicly-funded Catholic university, open to people of all faiths and of none and with teaching, learning and research inspired by 2,000 years of Catholic intellectual tradition.

ACU operates as a multi-jurisdictional university with seven campuses across four states and one territory. Campuses are located in North Sydney, Strathfield, Canberra, Melbourne, Ballarat, Brisbane and Adelaide. ACU also shares a campus in Rome, Italy with the Catholic University of America.

ACU is the largest Catholic university in the English-speaking world. Today, ACU has more than 34,000 students and 2,300 staff.³⁹

ACU graduates demonstrate high standards of professional excellence and are also socially responsible, highly employable and committed to active and responsive learning. ACU graduates are highly sought-after by employers, with a 94 per cent employment rate.⁴⁰

ACU has built its reputation in the areas of Health and Education, educating the largest number of undergraduate nursing and teaching students in Australia⁴¹ and serving a significant workforce need in these areas. Under the demand driven system, ACU sought to focus and build on these strengths.

Since 2014, ACU has had four faculties: Health Services; Education and Arts; Law and Business; and Theology and Philosophy. The consolidation of the previous six faculties has created a more efficient and competitive structure focused on the needs of industry and employment partners.

As part of its commitment to educational excellence, ACU is committed to targeted and quality research. ACU's strategic plan focuses on research areas that align with ACU's mission and reflect most of its learning and teaching: Education; Health and Wellbeing; Theology and Philosophy; and Social Justice and the Common Good. To underpin its plan for research intensification, ACU has appointed high profile leaders to assume the directorships, and work with high calibre members, in six research institutes.⁴²

In recent years, the public standing of ACU's research has improved dramatically. The 2019 Excellence in Research for Australia (ERA) assessment awarded ACU particularly high ratings in the fields of research identified as strategic priorities and in which investment has been especially concentrated. These include the broad fields of Medical and Health Sciences and Psychology and Cognitive Sciences where ACU received the top score of five – well above world standard – and in Education and Philosophy and Religious Studies in which ACU's research was rated as above world standard.

³⁹ Student numbers refer to headcount figures while staff numbers refer to full-time equivalent (FTE).

⁴⁰ *Graduate Outcomes Survey (GOS) 2016*.

⁴¹ Department of Education and Training, *2016 Higher Education Data Collection – Students, Special Courses*. Section 8, table 8.3

⁴² Australian Catholic University, *ACU Research* <http://www.acu.edu.au/research/research_institutes_and_programs>.