NRHA Submission to the National Review of Nursing Education,

August 2001

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NATIONAL RURAL HEALTH ALLIANCE INC.

NRHA Submission

to the

National Review of Nursing Education

August 2001

Working to improve health in rural and remote Australia

1st Floor, 4 Campion Street, Deakin ACT 2600

PO Box 280, Deakin West ACT 2600

Phone: (02) 6285 4660 * Fax: (02) 6285 4670

Email: nrha@ruralhealth.org.au * Website: www.ruralhealth.org.au

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Disclaimer: This NRHA Submission has the general endorsement of all of its Member Bodies. This does not mean that every one of its twenty-two national organisations necessarily supports every opinion in this submission. The separate submissions that may have been made to the Inquiry by some of the Alliance's individual Member Bodies may differ in emphasis or detail, including in their recommendations.

Summary and Recommendations

Summary

There are major problems for Australia's nursing workforce. They are most simply illustrated by two facts. First, nurses comprise over 55% of Australia's total health workforce. Secondly, there has been quite a different pattern of change in the rate of growth of the nursing workforce since 1986 compared with other health professions. The nursing workforce grew by 3.2% between 1986 and 1991 compared with 32 % for speech pathologists and physiotherapists, 18% for medical practitioners, 12% for chiropractors and 9% for ambulance officers and paramedics. Between 1991 and 1996 the relative differences were even greater and the nursing workforce grew by only half of one per cent.

As a result, the ratio of nurses in a clinical role to population declined from 1,171 per 100,00 in 1989 to 1,033 per 100,000 in 1999. This decline occurred in a period of significant increase in the overall demand for health services.

For remote and rural nurses there are particular challenges, due mainly to isolation and the relative lack of support from other health professionals. What this means is that, in the context of a national shortage overall, the nursing workforce in remote and rural areas is under particular stress. This is so much the case that many are talking about "the impending crisis" in remote and rural nursing, as the existing workforce there continues to age and becomes more difficult to replace.

There are also particular challenges — and some say a looming crisis — for nursing in the aged care sector.

This pressure on the national nursing workforce, of which the remote and rural aspects comprise a particular part, poses real challenges for all concerned. For the public the challenge is to understand better and therefore place a higher value on the nursing workforce and nursing as a profession. For education and training institutions the challenge is to make major contributions that will result in nurses who are better trained for what they will experience in the workplace and held in higher esteem — including by themselves. For governments there are two classes of challenge: first, to set in place policies to enhance the situation; secondly, to the extent that they are direct employers or the funders of agencies which directly employ nurses, to provide adequate resources for nurses to be properly remunerated and supported. This last is also the challenge for private sector employers of nurses.

Nursing organisations themselves as well as other health bodies have major responsibilities with respect to these challenges. The National Rural Health Alliance, as one such organisation, is happy to commit itself to whatever collaborative work it might do to help the situation. We are pleased to be able to make this submission to the Review as a small contribution along the way.

Although we are an Alliance of rural and remote organisations, the premise of this submission is that our interests can only be met through actions to solve the overall national situation. There are a number of ways in which the total number of practising nurses in Australia could be increased. Of these the Alliance does not first favour increasing the number of undergraduate nursing places. Instead, our emphasis is on increasing undergraduate completion rates, rates of transition to nursing work and the average length of time for which nurses remain in the profession. We also have a special interest in ways in which a greater number of nurses will spend time nursing in remote or rural areas at some stage in their career.

Some of the current problems are being met by an increased number of nurses coming to Australia temporarily; this is not a preferred or a sustainable answer to the problem.

We believe that steps to attract nurses into remote and rural nursing should begin even before prospective nurses enter undergraduate education. Employers have major responsibilities to put in place packages which more appropriately reflect the value and circumstances of nurses, particularly in remote and rural areas. This is especially the case in the aged care sector.

Australia needs some effective workforce planning for nursing (as well as for other health professions). This will require much better collaboration between the health policy and employment and training sectors. There is currently inadequate consultation on workforce supply and demand issues between employers, training institutions and departments for health and education

The Alliance argues for clearer and more collaborative arrangements between governments and other key parties. The Commonwealth should have a leadership role and through its responsibilities for higher education, migration and the aged care sector, take responsibility for national workforce planning to ensure a sufficient overall supply of nurses to provide for Australian's health care needs, wherever they are located. This role should also include identifying, promoting and, where appropriate, funding special measures to encourage increased numbers of young people from remote and rural areas to enter nursing as a career.

Through its leadership role in health policy and its interest in having a flexible and mobile health workforce, the Commonwealth should also encourage consistent approaches to terminology, role definitions, competencies and educational requirements for nursing in remote and rural areas. Policies on mutual recognition demand a cohesive approach across Australia to these issues.

Our recommendations in this submission include particular proposals to enable the Commonwealth to undertake these tasks.

State and Territory Governments should retain their responsibilities for the registration and regulation of nursing and for coordinating State nurse workforce planning and broader nursing policies across their jurisdictions. They must ensure that the legal and regulatory framework governing nurses working in rural and remote areas legitimises the actual roles of such nurses both as practised currently and emerging for the future; ensures protection for nurses providing such services; and ensures protection for communities from inadequately trained nurses being employed in such roles.

Universities and other organisations responsible for the education and training of nurses must ensure and, as necessary, enhance the continued relevance of their programs for nurses planning to work (or working) in remote and rural areas. This will involve cooperative arrangements with employers to ensure that programs are in tune with the demands on nurses from contemporary remote and rural health care practice. They should also strengthen their activities to encourage and support nursing students from remote and rural areas.

There are specific recommendations in this submission relating to these and other issues.

The Alliance is pleased to acknowledge the work of Ms Joan Lipscombe, Consultant to the NRHA for this submission.

We commend the submission to the Review and look forward to opportunities to promote our proposals.

Gordon Gregory
Executive Director, NRHA

28 August 2001

Recommendations

Recommendation 1

That the Review examine the outcome of key enquiries and reports over the last ten years relating to remote and rural nursing workforce issues to see the degree to which their recommendations have been implemented and the impacts of implementation where it has occurred.

Recommendation 2

That further recommendations relating to nurse employment, education and workforce planning be informed by the outcome of this examination, including:

- identifying barriers to resolving nursing workforce issues; and
- developing practical strategies for overcoming such barriers in the future.

Recommendation 3

That completion rates for nursing students be examined at each university providing undergraduate nursing programs to identify which universities, if any, have lower than average completion rates and the reasons for these.

Recommendation 4

That regardless of the outcome of Recommendation 2 universities set phased targets for increasing completion rates for nursing students to 90% in the medium to longer term.

Recommendation 5

That universities, in conjunction with professional nursing organisations and local communities, introduce enhanced support programs for nursing students at a high risk of not completing, targeting in the first instance those students who are likely to take up practice in remote or rural areas. These could include more special programs for induction or transition from school to university, rural clubs and mentor arrangements

Recommendation 6

That the regular national nursing labour force survey conducted by the Australian Institute of Health and Welfare seek to ascertain the trends in numbers of nurses re-entering the nursing workforce after a period out of it.

That if this is not possible then an alternative means of monitoring this should be devised and implemented.

Recommendation 7

That there be no short-term increase in the number of undergraduate nursing places until measures have been implemented and evaluated to improve:

- the image of nursing as a career;
- completion rates for undergraduate nursing courses;
- the proportions of new nursing graduates entering and remaining in the nursing workforce; and
- retention of nurses for longer in the profession.

Recommendation 8

That the Commonwealth Department of Education, Training and Youth Affairs take the lead in working collaboratively with nursing organisations, educational bodies and health services to design and implement effective measures to increase the attractiveness of nursing as a career.

These measures should include promotion to the public and to young people of the positive aspects of remote and rural nursing.

Recommendation 9

That policy-directed research be conducted by universities, nursing employers and nursing organisations to ascertain the reasons why some recently-graduated nurses do not work as nurses.

Recommendation 10

That once the results of this research are known, steps be taken by universities, nursing organisations and nursing employers to increase the proportion of new nursing graduates who enter and remain in the workforce as nurses.

Recommendation 11

Employers should put in place employment packages which more appropriately reflect the circumstances of remote and rural nurses and their central importance in work to secure good health outcomes in remote and rural Australia.

These packages should include:

- appropriate salaries, financial incentives and allowances;
- sufficient leave and relief and 'time-out';
- improved working conditions, such as more reasonable workloads, more family-friendly shifts and improved child care arrangements;
- good management and performance appraisal systems;
- back up and peer support;
- appropriate occupational health and safety strategies;

- orientation and familiarisation programs including cultural awareness and cultural safety;
- accommodation and family support;
- access to appropriate infrastructure such as IT, transport and radio; and
- continuing professional development and specialised training as appropriate, including study leave and financial assistance.

Recommendation 12

That State governments, nursing organisations, employer representatives, tertiary and secondary health services and education providers collaborate to deal with the following issues:

- better management training in people skills for remote and rural health service managers;
- improved career structures for nurses and health service managers;
- secondments for nurses from and to tertiary centres;
- transition support programs for new graduates that include at least a 3 month rotation to a rural or remote area with support from a mentor; and
- the provision of roving specialist nurses, for example in aged care, critical care and mental health.

Recommendation 13

Nursing organisations and employers should be consulted about the potential for collaborative professional activities in international forums, in conjunction with formal governmental promotions and communication, to ensure that to the extent that there is a future increase of internal and external migration of nurses, it does not prejudice the supply of nurses in key areas and specialties.

Recommendation 14

The Review should ask governments to investigate why the national workforce planning mechanisms for nursing recommended in 1994 have not been implemented.

Recommendation 15

That the Review itself identify and recommend to the Federal Government processes and structures that will make workforce planning for nursing more effective and which involve both Commonwealth and State health agencies, employers of nurses, nurse education providers and the Commonwealth Department of Education, Training and Youth Affairs.

Recommendation 16

That closer links be established between structures and processes for nurse workforce planning and those for other health occupations.

Recommendation 17

That, once established, these workforce planning mechanisms should give priority to assessing the nursing workforce needs of remote and rural areas.

Recommendation 18

That all stakeholders, including Commonwealth, State and Territory Government agencies, remote and rural health services, nursing organisations, nursing education bodies and rural and remote communities collaborate to find effective means to attract and retain a sufficient number of appropriately trained nurses working in remote and rural areas within an agreed national framework along the following lines:

- the Commonwealth Government to play a lead role in nurse workforce planning and remote and rural nursing issues with national implications (eg those affecting mutual recognition and workforce mobility);
- State and Territory governments to ensure that appropriate legal and regulatory frameworks are in place and to coordinate nursing policies and workforce planning across their jurisdictions;
- all jurisdictions to ensure direct program funding reflects the health needs and real costs of providing services in remote and rural areas, including costs of realistic employment packages for nurses and costs related to nurse education and ongoing skills maintenance and development;
- local governments, employers and nursing organisations work with universities in areas such as increasing the numbers of remote and rural nursing students and ensuring the continued relevance of their programs for nurses in remote and rural areas; and
- local governments and communities to explore all possible avenues for them to become actively involved in recruiting and supporting rural and remote nurses.

Recommendation 19

That all health policy be based on a social model of health which addresses the broad determinants of health and is driven by a whole of government approach. Other determinants of health, such as environmental degradation and the sustainability of natural resources, should be urgently considered in the planning and allocation of resources for health.

Recommendation 20

Rural development has to be recognised as a health issue. Without it there are declining communities, with little sense of direction, an uncertain future and poorly

motivated leaders. These result in poor health directly through the stress, frustration, and alienation that people feel. They also result in poor health indirectly through the difficulty for governments and the private sector of providing health services to areas that have small, sparse or declining populations (NRHA 1998).

Recommendation 21

That the Review identify, for the Government's consideration, innovative approaches to reduce the burden of HECS on nurses practising or intending to practise in remote or rural areas. On balance, approaches which reward nurses who actually practise in rural and remote areas are preferred, such as forgiving HECS debts for such nurses.

Recommendation 22

That Health and Education Departments and schools collaborate closely with local governments, universities, other health education and training bodies and local government to put in place programs with potential for short, medium and longer term impacts to encourage more young people from rural and remote areas to undertake undergraduate nursing courses, including:

- increased numbers of Commonwealth funded scholarships for students from remote and rural areas who are nursing students so that the numbers of nursing scholarships are pro rata equivalent to Commonwealth funded scholarships for medical students;
- HECS concessions as indicated in Recommendation 21;
- Commonwealth funded incentives for universities to implement programs to encourage students into nursing courses from rural backgrounds, building on the experience of such funding for rural medical students and the experiences of universities with successful access and participation programs for rural and remote students;
- careers promotion, information programs and use of role models to encourage an interest in rural and remote nursing as a career;
- popular radio and TV programs which present positive images of rural and remote nurses;
- research to see whether it is possible to attract more rural young men into nursing and if so the development of programs based on the results to achieve this;
- community education programs to increase understanding and acceptance in rural and remote communities about the value of higher education for local young people and their communities; and
- university campuses and community leaders in regional areas with nursing shortages identify this as a priority for collaborative activities focused on enhancing regional development, and human and social capital.

Recommendation 23

That the Review use the recommendations of the Council of Aboriginal and Torres Straight Islander Peoples developed from the 1997 Aboriginal and Torres Straight Islander Nursing Forum (Appendix 2) as a basis for its own recommendations on issues related to nursing and Aboriginal and Torres Strait Islanders, noting that some of the recommendations would directly benefit nurse education and training for all nursing students and the future careers of all nurses.

Recommendation 24

That universities with bachelor programs in nursing should urgently examine the curricula, teaching methods and the composition of their teaching staff to ensure their programs are suitable for and encouraging of remote and rural nursing practice. In particular they should ensure that:

- the programs meet a national minimum standard of content of Aboriginal and Torres Strait islander heath, culture and cultural safety;
- all students have the opportunity for clinical placements in remote or rural health services; and
- teaching staff include a good representation of nurses who have had substantial experience practising in remote and/or rural areas.

Recommendation 25

The maintenance of high quality health services in rural and remote Australia is contingent upon the continuing development of flexible education and training programs that are locally, culturally and socially appropriate. Undergraduate curricula for all health disciplines should include health promotion, primary health care, population health and cultural safety components. (Note: this recommendation is one of the priority fifteen from the 6th National Rural Health Conference.)

Recommendation 26

That universities, remote and rural health services, nursing organisations and governments collaborate to identify and remove barriers to nursing students being able to have appropriate placement in remote and rural health services.

Recommendation 27

That there be wide availability of suitable bridging programs which enable Enrolled Nurses in remote and rural areas to achieve advanced standing in Bachelor of Nursing Programs.

Recommendation 28

That nursing organisations, nurse regulatory authorities and education providers cooperate to ensure that Enrolled Nurse programs are nationally consistent, widely

available and meet national competency standards within a system of recognition of prior learning and formal articulation.

Recommendation 29

That universities, Rural Health Training Units, other training providers, nursing employers and nursing organisation collaborate to provide readily accessible modular post-basic training programs devised around the personal and professional needs of remote and rural area nurses and which use a variety of innovative delivery methods to ensure ready access for those working outside main centres.

Recommendation 30

That nurses working or intending to work in remote and rural areas be encouraged to undertake appropriate postgraduate preparation.

Recommendation 31

That rural health services and governments assist nurses to undertake appropriate post graduate preparation through the provision of scholarships and/or paid study leave.

Recommendation 32

That curricula for postgraduate programs in each of remote and rural nursing:

- reflect the differences between remote and rural area practice, while containing a substantial common core content;
- are available at the three levels of graduate certificate, graduate diploma and masters; and
- are sufficiently consistent nationally to enable mobility and flexibility of the nursing workforce and economies in curriculum development, while permitting flexibility to meet local needs.

Recommendation 33

That postgraduate programs for rural and remote area nurses be designed using the following guidelines:

- integration between clinical and theoretical components;
- involvement of credible, experienced rural and remote area nurses;
- articulation, flexibility in access and delivery, recognition of prior learning, use of adult learning principles;
- affirmative action for minority and disadvantaged groups;
- the use of clinical preceptors;

- sufficient resources and affordability to ensure sustainability;
- regular evaluation including an assessment of their impact on workforce issues such as work performance and recruitment and retention rates; and
- delivery processes which are collaborative, multidisciplinary and tailored to the needs of the specialty, services and the learner.

Recommendation 34

That postgraduate programs for rural and remote area nurses be based on national competency standards for each of remote and rural practice which define the requirements for these two advanced levels of practice and which are validated against practice.

Recommendation 35

That rural undergraduate health clubs place a special focus in their activities on presenting a positive image for rural and remote nursing and encouraging nursing students to spend some time during their careers working in remote and rural areas.

Recommendation 36

That the Commonwealth establish a scholarship scheme for student nurses similar to the John Flynn Scholarship Scheme for medical students. When fully operational this Scheme should provide at least 300 scholarships per year for nursing undergraduates.

Recommendation 37

That the Commonwealth Government urgently initiate processes through the Australian Health Ministers' Advisory Council to encourage the States and Territories, key nursing organizations, nurse registration authorities and general practice bodies to negotiate and adopt mutually consistent approaches to advanced nursing practice and 'nurse practitioner' issues in such areas as scope of practice, education and training, career structures, remuneration and legislative underpinning. In undertaking this work there should be recognition of the collaborative models that exist between GPs and nurses in remoter areas and the highest priority should be for remote and rural advanced nursing practice.

Recommendation 38

That the Commonwealth provide resources and work collaboratively with the agencies themselves, the States, and professional and community organisations to support a broadened role for agencies such as the Divisions, Rural Workforce Agencies, University Departments of Rural Health, and Rural or Remote Health Training Units. This support would in no way prejudice the autonomy of the agencies and would be designed to allow them more effectively to encompass the needs of all health occupations.

Recommendation 39

That regional universities be funded to establish pilot programs which have a common core curriculum across all health disciplines, including medicine where the university has or is expecting to have a medical school.

Recommendation 40

The Review should note the recommendations elsewhere from the Alliance on a '30% fair share' for rural and remote areas, and for examination of alternative funding structures for health services in rural and remote areas to lead to a distribution of health funds that is based more squarely on relative health needs.

Section A Introduction

The National Rural Health Alliance is a well-established and highly respected national community-based organisation. We are the peak national body for organisations with an interest in rural and remote health.

We have a membership of 22 national organisations representing health professionals and managers, health services, Indigenous people, the residents of rural and remote areas, and education and training providers.

Our mission and aims include:

- working for better health in rural and remote Australia by seeking improvements in rural health services and policies, including those affecting the rural health workforce; and

- promoting collaboration between all relevant parties for improvements in health and health services in rural, regional and remote Australia.

Our main roles in remote and rural health are to:

- advocate for improvements;

- develop policies and promote research;

- disseminate information; and

- facilitate networking and a range of collaborative activities between those striving to improve health in remote and rural Australia.

The Alliance also manages the John Flynn and Rural Australia Medical Undergraduate Scholarship Schemes on behalf of the Commonwealth.

Together, these various roles give the Alliance an intimate knowledge of issues affecting remote and rural nurses. This is the main focus of our submission and we have not directly addressed issues specific to urban nurses.

Despite this we believe that some of the issues facing remote and rural nurses derive from system-wide problems affecting nursing overall. There is not a separate remote and rural nursing workforce — all nurses are part of the total nursing workforce and are affected by the broad environment in which nurses train and work. We have raised some of these systemic issues and in some cases suggested solutions which would affect nursing overall.

By taking this broader view it could be seen that the Alliance is moving away from our specific charter for health issues relevant to remote and rural areas. We do not consider that to be the case. We see these systemic changes as necessary if there is to be a flexible, well-distributed and stable nursing workforce appropriately educated and effectively deployed to provide for the health needs of remote and rural communities.

Several Member Bodies of the Alliance are preparing separate submissions to the National Review into Nursing Education. These organisations have also contributed to varying degrees to the preparation of the Alliance's submission, which has the endorsement of all our Member Bodies. This endorsement indicates general support for the Alliance's position, but it does *not* mean that every organisation necessarily supports every word in this submission.

Consequently the submissions from the Alliance's individual Member Bodies may differ in emphasis or detail, including in their recommendations. These differences reflect the specific concerns of each group and their perceived solutions and should help the Review to understand the issues from a wide range of perspectives.

Section B Context in which remote and rural nurses work

> The development of health care in rural and remote Australia has, however, heavily relied on the work of nurses. For many years, nurses have provided extensive health services without any readily available access to medical or allied health personnel other than via telecommunication. (Bradley and McLean 1999 p.1)

B1 The broad environment

There are many contextual factors which affect health professionals working in rural and remote Australia. While some of these are also relevant for city-based providers, many are unique, or at least especially important, in remote and rural areas. These issues are widely discussed in the literature. See for example *Australia's Health 2000* (AIHW 2000a), *Health in Remote and Rural Australia* (AIHW 1998), *Access to health-care services in remote areas* (Wakerman 1999), *The delivery of sustainable rural and remote health services* (Bryant and Strasser 1999), *Healthy Horizons* (National Rural Health Policy Forum 1999) and the Proceedings of six National Rural Health Conferences held between 1991 and 2001 (available at www.ruralhealth.org.au).

Some of these broad contextual factors are listed below.

- Poor health status of the rural and remote population compared with people of urban areas.
- Complexities stemming from confusion about the roles and responsibilities of the three levels of government in the financing, planning and provision of health care services.
- Overall budgetary constraints and pressures.
- Perceived inflexibilities in health funding and inappropriate use of short-term funding.
- Changing locations and emphases in health care, for example:
  - consumer focus;
  - emphasis on greater integration and coordination of services;
  - less reliance on institutional care, eg aging in place, community-based mental health care and hospital in the home; and
  - greater emphasis on primary health care.
- Changing disease patterns.

- Higher proportions of Indigenous peoples in rural and, especially, remote areas.
- Changing demographics, eg aging population, declining population in some areas, expanding in others.
- Rapidly expanding knowledge base and need for competence and flexibility across a wide range of health needs.
- Increasing use of IT.
- Increasing use of medical technologies.
- Isolation, both professional and geographic.
- High levels of autonomy.
- Relative undersupply of all health professionals.
- Less support staff, with professionals therefore having a greater role in administrative matters.
- Impact of economic downturn in some areas of regional Australia.
- Limited infrastructure, eg transport and telecommunications.

These factors contribute to making the role of heath professionals in rural and regional areas quite different from that of their urban counterparts. This has largely been recognised during a time of growing interest in remote and rural health issues over the last ten years.

On the workforce front, for reasons related to perceptions of Commonwealth v State/Territory responsibilities, most national attention has focused on rural general practice. Overall and largely as a result of the Medicare agreement, most funding for medicine comes via the Commonwealth while most for nursing comes via the States.

However nurses are the largest and most widely-dispersed health professional group in rural and remote Australia. The Alliance has welcomed efforts to attract and retain doctors for rural and remote practice. Activities such as the Rural Incentives Program, John Flynn Scholarships and Rural Australia Medical Undergraduate Scholarships Scheme provide very useful models and precedents for the rural and remote nursing workforce, for which there has been much less action.

> Increasingly, national and regional attention has been paid to the importance of rural health issues and rural practice — most notably through the regular concern at the shortage of rural medical practitioners willing to work in perceived isolation from many of their peers. A major series of initiatives was taken through a national General Practice Rural Incentives Program which supported the recruitment and retention of doctors in rural and remote communities. The position of rural and remote nurses has been less celebrated and the subject of fewer initiatives by both government and the sector. (Bradley and McLean 1999 p.1)

B2 Remote and Rural Nursing Initiatives

Several recent initiatives have been developed to help to alleviate the difficulties faced by remote and rural nurses.

- *Australian Remote and Rural Nursing Scholarships Scheme*. Funded by the Commonwealth, these scholarships commenced in June 1997. They provide $600 000 a year to support rural and remote enrolled and Registered Nurses to undertake continuing professional education and training to enhance their skills (DHAC 2001).

- A commitment in the 2001 Commonwealth Budget to fund:

  - 100 scholarships per annum for nursing students from rural areas;

  - 10 scholarships per year for Aboriginal and Torres Strait Islander nursing students or other health workers who wish to upgrade their qualifications; and

  - $104m over four years to enable doctors to employ more practice nurses in areas where access to medical services is limited, including, but not restricted to, rural and remote areas. These funds also include 400 scholarships each year to assist former rural nurses wishing to re-enter the nursing workforce (Wooldridge 2001).

- A number of State and Territory initiatives including:

  - nurse practitioners in NSW, South Australia and Victoria. As an example, NSW has just appointed its first nurse practitioner in a rural area, at Wanaaring, providing health services to a community of 450 people in a town 190 km north-west of Bourke. Services include limited prescribing and referrals to other health practitioners (Shine 2001). This follows an extensive period of research and consultation on nurse practitioners (see for example NSW 1995);

  - Isolated Practice endorsement in Queensland;

  - Rural Health Policy Cadetships in Western Australia, available to undergraduates in any health course to work in an area of rural health policy development during their summer vacations; and

  - rural nursing scholarships are available through some State Governments, universities and nursing organisations.

The Alliance welcomes these and other initiatives of recent years (NRHA 2001a). We remain concerned, though, about:

- the piecemeal approach to dealing with health issues in rural and remote areas without an overall 'blueprint' for rural and regional development (NRHA 2001b);

- the tendency for the Commonwealth to fund initiatives for rural and remote nurses (and allied health practitioners) mainly through General Practice (AARN 2001); and

- the lack of an integrated, cohesive strategy for dealing with nursing (and allied health) workforce issues affecting remote and rural Australia (NRHA 2001c).

Undoubtedly, fostering a team approach is vital to achieving good health outcomes in remote and rural Australia. Private general practice must be part of this team approach and nurses employed in general practices provide a valuable and growing role. However, providing funding for remote and rural nurses largely through general practice structures can be counter-productive. Some Member Bodies of the Alliance feel that it is likely to inhibit innovative models of health care delivery through perpetuating the outdated notion that nurses are primarily 'the handmaidens of doctors' rather than highly trained, professional health care workers with their own unique body of knowledge and skills (AARN 2001b).

The numbers of undergraduate nursing scholarships being funded by the Commonwealth represents a much smaller proportion of rural nursing students than the scholarships available to rural medical undergraduates relative to their overall numbers. In the year 2000 the Alliance was pleased to welcome over 500 rural medical scholarships for a field of study with approximately 1200 new entrants a year. This compares with the 110 announced for rural nursing with approximately 9000 new entrants a year.

Section C Previous recommendations on nursing education and workforce issues

> The nursing profession (and in this case — particularly the ranks of rural nurses) is heartily sick of the number of inquiries which are held but from which governments rarely implement any innovative recommendations and strategies. There is a perception that inquiries are conducted, they are shelved for a few years until the problems rise to the surface again, then a further range of inquiries are conducted — but nothing substantial happens. (K. Malko-Nyhan) [1]

Nurses and health students remain skeptical that there will be any meaningful, cohesive and strategic approach to addressing rural and remote nursing issues as a result of this National Review of Nurse Education. They hope to be proved wrong.

Their skepticism is reinforced by the establishment of the parallel Senate Community Affairs References Committee 'Inquiry into Nursing'.

The reason for nurses' skepticism is that many of the issues which are today apparent in nurse education and nurse workforce planning have already been identified through a range of enquiries and research projects in earlier years. These projects have generally made similar recommendations, but little has changed (NSW 1998). Some examples are listed below.

C1 National Level

- The National Review into Nurse Education in the Higher Education Sector — 1994 and beyond.

  Some recommendations of that review were specific to remote and rural nursing, for example:

  12.3.2 Support for beginning practice

  14.2 Centres for Remote and Rural Nursing

  14.3 Nursing students from rural backgrounds

  14.5 Role of distance education and open learning in remote areas

  14.6 Aboriginal and Torres Strait Islander peoples and nursing education in universities

  14.7 Articulation of courses preparing Aboriginal Health Workers

  Other recommendations were more generic, but many were relevant to remote and rural nursing, for example those relating to curriculum, teaching methods, clinical placements and workforce planning.

[1] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing.*

- Australian Health Ministers' Advisory Council.

  A series of reports and projects over the last ten years including:

  - one which examined the comparative roles of remote area nurses, Aboriginal Health Workers and rural doctors; and
  - Chief Nursing Officers project examining issues across Australia relating to remote area nurses.

- *The National Review of Specialist Nurse Education* (Russell, Gething and Convery 1997).

  Recommendations from this report included:

  - adopting agreed definitions and nomenclature of nursing specialists;
  - defining levels of qualifications and credentialing processes;
  - ensuring credit transfer and articulation;
  - planning and delivery of specialist nurse education;
  - developing a framework for the provision of specialty nursing in Australia and its subsequent dissemination and implementation; and
  - improving collaboration between key parties.

- National Nursing Workforce Forum in 1999 (*Rethinking Nursing*).

- The National Rural Health Alliance

  The Alliance undertook work on aspects of advanced nursing practice in 1997 and 1998, including commissioning research (McMurray et al 1998) and consulting with a wide range of interested parties. As a result in 1998 the Alliance provided recommendations to the Commonwealth Department of Health and Aged Care on advanced nursing practice in remote and rural areas. The recommendations provided both:

  - a national framework for the educational preparation and ongoing professional development for nurses practising or wishing to practise at advanced levels in remote and rural areas; and
  - suggested processes to advance the work.

  These recommendations are at Appendix 1.

- *Rural Health Stocktake* (Best 2000).

This concluded that there was an overall shortage of nurses in rural areas and recommended funding for training for 'clinical nurse consultants' and nurses employed in multipurpose services.

- National Workshop on advanced nursing practice in rural and remote areas (NARHERO 2001).

  This forum involved all key parties, including national and State nursing organisations, those involved in research, education and training of nurses and representatives of other health professionals, governments, the Australian Health Ministers' Advisory Council, consumers, the National Rural Health Alliance and Indigenous groups. Its 12 recommendations are mainly concerned with setting in place a national framework and strategy to define and formalise the roles of nurses working in remote and rural areas and to support these roles through appropriate legislation, classification, education and training, mutual recognition, remuneration and recruitment and retention programs.

- There are also some important current inquiries, notably those of the Australian Health Workforce Advisory Committee.

  Its nursing workforce review is focusing initially on some of the specialised nursing workforce. Two working parties have been convened, to review the midwifery and critical care nursing workforce and to provide a report by mid 2002 on the number, composition, distribution and workforce characteristics of the current critical care workforce, and its optimal supply (including distribution). Projects looking at the aged care, mental health and emergency nurses will follow (AHWAC 2001).

C2 State level reviews

These include:

- Nursing Recruitment and Retention Taskforce (NSW 1997)

  Though not specific to remote and rural, the recommendations in this report were to apply throughout NSW.

- Rural and Remote Nursing Summit (NSW 1998)

  This Summit of representatives of nursing, community and education organisations made 8 recommendations to improve recruitment and retention of the nursing workforce in remote and rural areas. Ideas covered included:

  - establishing remote and rural nursing councils;
  - joint strategies with local communities to attract and retain nurses;
  - ways to improve privacy and time out; and
  - accommodation for students and relieving staff.

- A Ministerial Taskforce in Queensland

  This examined nursing recruitment and retention, and identified a range of emerging problems in attracting and retaining nurses including in rural and remote areas. Its remote and rural specific recommendations included:

  - scholarship programs for nurses working in remote and rural areas;
  - rotations for remote and rural nurses to tertiary and secondary facilities;
  - payment of supernumerary costs of recent graduates working in advanced roles in rural facilities;
  - partnership support from larger to smaller health services;
  - research to examine high turnover rates in some rural districts;
  - relocation expenses for nurses moving to rural areas; and
  - development and implementation of standards for accommodation for remote area nurses (Queensland 1999)

- Victorian Rural Nurse Project: Workforce Database (Duffy et al, 1999)

  The study resulted in thirteen recommendations about the characteristics of rural nurses and their role in rural Victoria. It included proposals that the State authorities collaborate on innovative recruitment packages to attract nurses to rural practice, that there be specific attention to rural nurses in aged care, and to the importance of remuneration, continuing education and mentoring for nurses in rural Victoria.

- A study entitled *Factors Influencing the Recruitment and Retention of Rural and Remote Area Nurses in Queensland* (Hegney et al, 2001).

  The study reports on the reasons for Registered and enrolled rural and remote nurses leaving or staying in the eighteen rural and remote Area Health Service Districts in Queensland in which there was a higher than average turnover rate from February 1999 to May 2000. There were five major factors influencing decisions to leave: management practices with the health facility; emotional demands of the work; workplace communication; management recognition for their work; and family responsibilities. Work-related factors were predominant influences on decisions of nurses to stay in rural and remote area nursing practice.

C3 Other research reports containing pertinent recommendations

Other research reports containing pertinent recommendations include:

- *Generating the Educational and Research Priorities of Rural and Remote Area Nurses* (Bell, Chang and Daly 1995);

- *An Overview of a study into the Role and Function of the Rural Nurse in Australia* (Hegney, Pearson and McCarthy 1997);

- *Education, Training and Professional Support for Rural Nurses: a National Survey of Rural Health Training Units* (Jones and Blue 1997); and

- *A report on the findings from the AARN Membership Survey: a National Investigation and Support project for Australian Rural Nurses* (AARN 1999).

The Review will want to know why there has been so little follow-up action on key areas identified in these and other reports. Given that the recommendations are generally developed by people who are extremely knowledgeable about nursing issues, it seems unlikely that they are inappropriate. The more credible explanation is that there are substantial barriers yet to be addressed hindering progress on nursing workforce and education issues in rural and remote Australia.

If this is the case, future progress and the longer-term availability of an effective and sufficient nursing workforce in remote and rural areas will depend on the Review identifying these barriers and articulating realistic approaches to removing or reducing them.

> It can be disheartening as a future rural health practitioner to read reams of reports and recommendations and to see little or nothing being done to action them. Australia's future nursing and other health practitioners need to see strong and committed leadership from all levels of government and professional bodies in addressing rural nursing issues. Failure to provide this leadership can dampen the enthusiasm of budding rural practitioners, and to do so is to deny rural Australia a most valuable resource: a committed, energetic and inspired workforce.
> (J Fitzpatrick)[2]

Barriers to dealing effectively with nursing issues in remote and rural Australia (and more broadly) might include:

- the lack of national leadership;

- lack of clarity about which level of government is responsible for what aspects of nursing workforce issues;

- the relatively low status and high numbers of nurses (and thus perceived overall costs of policy actions) compared with doctors where much greater efforts have gone in educating, attracting and retaining them in rural areas;

- resourcing issues;

- opposition from some influential medical organisations to some innovative approaches to nursing in rural and remote areas;

- the lack of effective structures for interaction and agreement and associated poor coordination between the key players in workforce planning and nurse education; and

[2] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing*.

- fragmentation of developments in education, training and new nursing models of practice.

Recommendation 1

That the Review examine the outcome of key enquiries and reports over the last ten years relating to remote and rural nursing workforce issues to see the degree to which their recommendations have been implemented and the impacts of implementation where it has occurred.

Recommendation 2

That further recommendations relating to nurse employment, education and workforce planning be informed by the outcome of this examination, including:

- identifying barriers to resolving nursing workforce issues; and
- developing practical strategies for overcoming such barriers in the future.

Section D The effectiveness of current arrangements for the education and training of nurses

D1 Completion rates

> I started my hospital training with 36 others and finished with 13. (Victoria Gilmore)[3]

Completion rates, that is the proportion of students commencing a course who complete it, have a substantial impact on the flow of nurses from pre-service education to the workforce. If they are low, the pool of potential nurses is less than it otherwise would be. Also, substantial resources, both for the universities and for the individuals themselves, are wasted.

Nursing completion rates are overall higher than those for most other fields of study. Around 74% of those enrolling in a university nursing course in 1992 had completed their courses by 1997. This is somewhat less than in other health courses and veterinary science, but greater than the figures for most other fields of study such as education, legal studies, architecture, business and economics, arts and engineering (DETYA 1999a).

The Alliance is unaware of the degree to which these completion rates vary between institutions, but has been advised of one course where 32% of a cohort of nursing students commencing in 1999 had dropped out less than half way through the course[4]. If examination of this issue reveals substantial variation between universities, a potential policy response would be to implement programs to try to raise completion rates in universities where nursing completions are lower than average. Information about differential rates of completion between institutions would also be valuable in identifying ways to achieve higher rates overall. The Review will no doubt be interested in the reasons for such differential rates.

Even though the completion figure for nursing students is relatively high, over 25% of those enrolling in a nursing course have not completed after 5 years. Characteristics of those most at-risk of not completing any university course include:

- older students, especially those without previous higher education experience or without professional qualifications;
- being a part-time or external student;
- those with lower TER scores;
- being male;
- being an Aboriginal or Torres Strait Islander;

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3 Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing.*

4 Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing.*

- being from a non- English speaking background; and
- being from an isolated area (DETYA 1999).

This information provides a useful guide for implementing programs to increase support for nursing students at higher risk of not completing. Several of the risk factors are particularly relevant to potential rural and remote area nurses. If the completion rate could be increased to that of veterinary science at around 90%, an extra 2 350 or so nurses would graduate each year.

Recommendation 3

That completion rates for nursing students be examined at each university providing undergraduate nursing programs to identify which universities, if any, have lower than average completion rates and the reasons for these.

Recommendation 4

That regardless of the outcome of Recommendation 2 universities set phased targets for increasing completion rates for nursing students to 90% in the medium to longer term.

Recommendation 5

That universities, in conjunction with professional nursing organisations and local communities, introduce enhanced support programs for nursing students at a high risk of not completing, targeting in the first instance those students who are likely to take up practice in remote or rural areas. These could include more special programs for induction or transition from school to university, rural clubs and mentor arrangements

D2 Increasing the average number of years that nurses spend working in the profession

Many nurses spend a relatively short period working as nurses. Of the estimated 257 662 nurses Registered or enrolled in Australia in 1999, 24 571 or 9.5% were not working in nursing. Two thirds or 16 431 of these were not employed at all, of whom only 4782 were looking for work in nursing (AIHW 2000). The number of nurses not in the nursing labour force has been fairly steady since 1994, being between 23 659 and 27 996, following a big fall from 38 117 in 1993.

These nurses are ones who have an ongoing interest in nursing as they have maintained their registrations or enrolments with the relevant registering authority.

There are others with nursing qualifications who have cut their ties with nursing — at least to the extent of not maintaining their registrations or enrolments.

Thus there is a large pool of already qualified nurses who might be enticed back into the nursing workforce. Some of the measures for increasing recruitment to remote and rural areas outlined in Subsection E3 below would have an impact here. Similarly the recently-announced Commonwealth funding to assist rural nurses re-enter the workforce as practice nurses should encourage some rural and remote nurses back into the profession (Wooldridge 2001).

Recommendation 6

That the regular national nursing labour force survey conducted by the Australian Institute of Health and Welfare seek to ascertain the trends in numbers of nurses re-entering the nursing workforce after a period out of it.

That if this is not possible then an alternative means of monitoring this should be devised and implemented.

Given the big potential to increase the nursing workforce through other means, the Alliance suggests that increasing the numbers of undergraduate nursing places should not be a priority. Other steps recommended in this section should be first implemented and evaluated before further considering whether to increase undergraduate nursing places.

Recommendation 7

That there be no short-term increase in the number of undergraduate nursing places until measures have been implemented and evaluated to improve:

- the image of nursing as a career;
- completion rates for undergraduate nursing courses;
- the proportions of new nursing graduates entering and remaining in the nursing workforce; and
- retention of nurses for longer in the profession.

Section E Factors in the labour market that affect the employment of nurses and choice of nursing as an occupation

E1 Promotion of nursing as a career

The total number of nursing students enrolled in undergraduate basic nursing bachelor courses has declined from 24 569 in 1994 to 21 397 in 1999. The pattern for commencing students is similar: the number of persons commencing undergraduate basic nursing bachelor courses declined by 6.5% over the same period (DETYA 2000, Table 101).

This decline in the numbers of students enrolled in basic nursing courses has coincided with the increasing overall shortage of nurses in Australia. Thus there is apparently a case for increasing the numbers of nursing students enrolled in bachelor nursing courses but, as argued below in E7, the Alliance believes that this is a low priority compared with other measures to increase the supply of nurses. It is not clear whether the decline is due to a reduced number of funded places or to universities being unable to fill the available places.

There are some practical barriers to achieving an increase the number of undergraduate nursing students. For example a serious issue is whether or not it would be possible to arrange sufficient placement opportunities to ensure students have access to high quality practical experience. There is already evidence of increasing difficulties in finding sufficient suitable placements, especially in non-hospital locations and in remote and rural areas. Issues include:

- the extra pressures on already-stretched nursing staff to provide training and supervision;
- the lack of suitable accommodation; and
- costs to student, universities and health facilities of arranging and managing the placements.

> We could double the numbers of student nursing place in the universities, but we would not then get them onto clinical placements, an essential part of their training and registration requirements. Staff shortages, decreasing hospital budgets affecting the availability of mentors/preceptors, or just placement coordinators are already impacting on the ability of many smaller and even some regional hospitals and community health services to take student nurses on placements. Universities are already hotly competing for dwindling places. Also the increasing numbers of medical students in some areas are impacting on the ability of services to take nursing students eg Wagga Wagga and the University of New South Wales medical clinical school. This has not been recognised or widely published yet, but will be a major barrier in the very near future. (Lawler 2001)

Even if extra place were to be provided, there may be some doubt about whether there would be sufficient suitable students to fill them. There are substantial barriers to the recruitment of sufficient, suitable new entrants to the nursing profession including:

- the relatively low status of the nursing profession despite the high regard expressed by the general public for nurses;
- a public under-valuing of nursing, due in part to poor understanding of:
  - the profession's complexity of practice;
  - its educational base;
  - the extent of decision making required of nurses; and
  - the degree of independence in nursing work;
- requirement for shift work combined with relatively low wages;
- Registered Nurses commencing their careers with a HECS debt higher than their annual wage;
- an increased range of career options for women, the traditional major source of nurses; and
- perceived poor career opportunities within nursing compared with other professional groups.

> The major contributing factors in the retention of qualified nurses in the workforce are in part structural, such as pay, work conditions and job satisfaction, the lack of recognition/power in the health care team, the lack of social support systems (especially in rural and remote health care), along with an array of other factors. The nursing profession view the development of the Nurse Practitioner role as a means of encouraging staff retention by providing alternative career pathways. (GPPAC, 2001)

These barriers are a challenge and not easily removed. There have been numerous suggestions that there should be a concerted effort to advance nursing as a career (see for example Queensland 1999). The Alliance considers that a well-planned, strategic approach to highlighting the many positives of a nursing career could help to increase its attractiveness. Such a campaign should be combined with measures to deal with many of the issues in education, training and in the workplace which act to deny nurses professional satisfaction and appropriate financial rewards from their work. The measures could include good news stories in print and other media and using popular TV and radio programs such as Australian Story.

Recommendation 8

That the Commonwealth Department of Education, Training and Youth Affairs take the lead in working collaboratively with nursing organisations, educational bodies and health services to design and implement effective measures to increase the attractiveness of nursing as a career.

These measures should include promotion to the public and to young people of the positive aspects of remote and rural nursing.

E2 Increasing the proportion of graduating nurses who enter and remain in nursing

Graduating nurses have little difficulty in obtaining employment after graduation. In 2000, 95% of bachelor initial nursing graduates who were available for full-time work were in full-time employment within 4 months of qualifying. This compares with the average for all graduates of 83.6% (GCCA 2000).

The remaining such nurses are either in part-time work, full-time study or seeking work.

Some of these nurses are not working as nurses. Four months after graduating 5.1% of basic nursing graduates from the 1998 graduating cohort who were employed full-time were employed in positions outside nursing. The equivalent figure for post-basic nursing graduates was 9.6%. Add to this the numbers who do not complete and those who are working part-time and a picture emerges of quite a large pool of potential nursing time not available to the health system from new graduates (GCCA 1999b).

Improving the proportion of newly-graduated nurses who enter nursing would be another way of increasing the nursing labour force with few resource implications. Nursing degrees are highly specific to a career in nursing. Although undergraduate nursing programs teach some generic skills of use in other types of employment, graduating large numbers of people as nurses who never enter nursing is wasteful of many of the resources which go into this specialised education.

Recommendation 9

That policy-directed research be conducted by universities, nursing employers and nursing organisations to ascertain the reasons why some recently-graduated nurses do not work as nurses.

Recommendation 10

That once the results of this research are known, steps be taken by universities, nursing organisations and nursing employers to increase the proportion of new nursing graduates who enter and remain in the workforce as nurses.

E3 Making rural and remote nursing a more attractive, long-term career option for nurses

The Alliance believes that steps to attract nurses into rural and remote nursing should begin before prospective nurses enter basic nurse training.

A range of initiatives is also desirable to help nursing students, whatever their geographic origins, to develop a positive attitude to working in remote and rural areas. We outline some possible approaches below.

Many of the concerns of remote and rural nurses and their representatives are closely linked with their employment conditions. As a consequence, a number of the initiatives suggested in previous reports to deal with these concerns are clearly the responsibilities of employers. The Alliance considers that it is time that employers accepted more responsibility for attracting and retaining nurses in remote and rural areas.

Recommendation 11

Employers should put in place employment packages which more appropriately reflect the circumstances of remote and rural nurses and their central importance in work to secure good health outcomes in remote and rural Australia.

These packages should include:

- appropriate salaries, financial incentives and allowances;
- sufficient leave and relief and 'time-out';
- improved working conditions, such as more reasonable workloads, more family-friendly shifts and improved child care arrangements;
- good management and performance appraisal systems;
- back up and peer support;
- appropriate occupational health and safety strategies;
- orientation and familiarisation programs including cultural awareness and cultural safety;
- accommodation and family support;
- access to appropriate infrastructure such as IT, transport and radio; and
- continuing professional development and specialised training as appropriate, including study leave and financial assistance.

Other challenges require collaborative action from a number of parties, not just direct employers of nurses.

Recommendation 12

That State governments, nursing organisations, employer representatives, tertiary and secondary health services and education providers collaborate to deal with the following issues:

- better management training in people skills for remote and rural health service managers;
- improved career structures for nurses and health service managers;
- secondments for nurses from and to tertiary centres;
- transition support programs for new graduates that include at least a 3 month rotation to a rural or remote area with support from a mentor; and
- the provision of roving specialist nurses, for example in aged care, critical care and mental health.

Section F Key factors governing the demand for and supply of nursing education and training - the supply of nurses in rural and remote areas: numbers, distribution, characteristics and qualifications

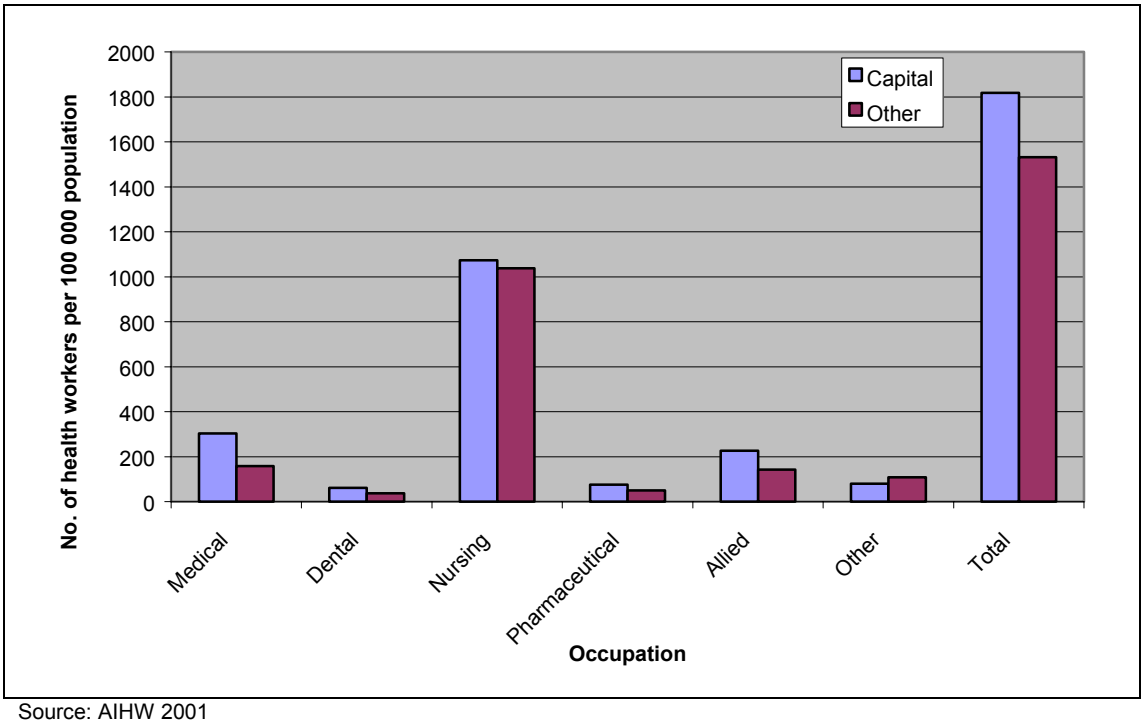
> Anecdotally there are 1000 rural nurse vacancies in Victoria. The higher acute service wages are reducing the number of nurses in aged care facilities. The average age is getting higher, and as the current 'backbone' of rural nurses retires there will be a crisis. (J Lawrence)[5]

F1 Numbers

The Australian Institute of Health and Welfare estimated that in 1996:

- the nursing workforce (ie those working in one of the nursing occupations including personal care assistants and nursing assistants) in Australia comprised almost 232 000 persons (AIHW 2001) (see Fig 2);
- this is 57.4% of the total engaged in health occupations (AIHW 2001);
- in non-capital cities the nursing workforce of 70 252 represents 68% of those engaged in health occupations (AIHW 2001).

Figure 1 Health labour force in capital cities and other regions 1996



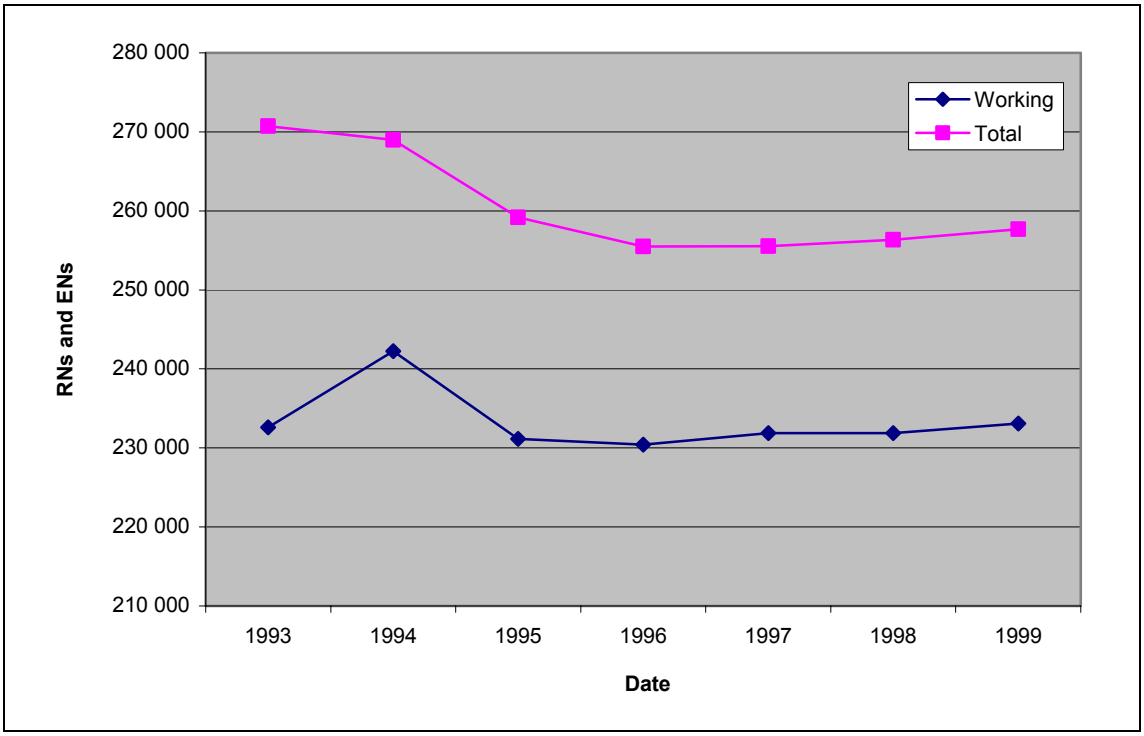
Source: AIHW 2001

[5] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing*.

In 1999 there were an estimated 257 662 persons Registered or enrolled in Australia as nurses, of whom 221 998 were actually employed in nursing in Australia. This represents a fall of 4.8% in total registrations since 1993 (AIHW 2000).

Figure 2 shows that the trends in total numbers of Enrolled and Registered Nurses and their number actually working are very similar. There has been little change in these numbers in recent years. The gap between the two groups is consistently around 25 000 to 30 000. That is, 25 000 or so Registered and Enrolled Nurses are not in the nursing workforce at any given time. Of these, around 12 000 are employed elsewhere (AIHW 2000).

Figure 2 Trends in the total numbers of Registered and Enrolled Nurses in Australia 1993–99



Within the nursing workforce there has been a substantial fall in the relative numbers of Enrolled Nurses. Between 1989 and 1999 the proportion of the total nursing workforce made up of Enrolled Nurses fell from 26.6% to 16.3% (AIHW 2000).

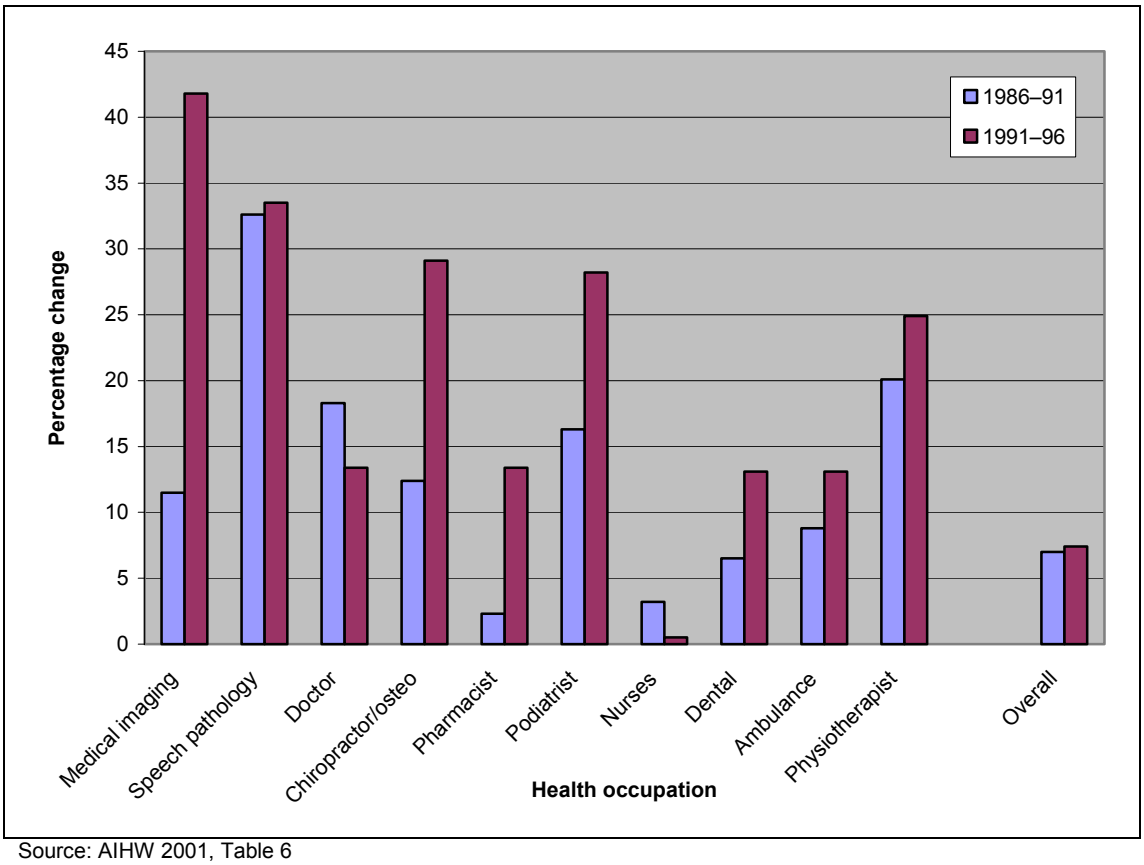
This pattern of relative stability — or lack of growth — in the number of nurses employed in nursing contrasts markedly with the pattern for other health professionals. Table 1 and Figure 3 show the rates of growth in other health professions from 1986 to 1996.

Table 1 Increase in numbers in selected health occupations 1986 to 1996

Health occupation	% increase in numbers 1986–91	% increase in numbers 1991–96
Medical imaging professional	11.5%	41.8%
Speech pathologist	32.6%	33.5%
Chiropractor and osteopath	12.4%	29.1%
Podiatrist	16.3%	28.2%
Physiotherapists	32.1%	24.9%
Medical practitioners	18.3%	13.4%
Pharmacists	2.3%	13.1%
Dental practitioners	6.5%	
Ambulance officers and paramedics	8.8%	7.6%
Nurses	3.2%	0.5%
Total: all health and related occupations	4.1%	18.5%

Source: AIHW 2001, Table 6

Figure 3 Comparative percentage growth rates in the numbers in selected health occupations 1986–1996



Source: AIHW 2001, Table 6

There is a range of possible explanations for the marked contrast between changes in the numbers of nurses and other health professionals. Whatever the explanation, the trends emphasise a nursing workforce that is under stress. The ratio of nurses in clinical roles has declined from 1171 per 100 000 people in 1989, to 1033 per 100 000 in 1999 (AIHW 1999). This relative decline has occurred over a period of large increases in the overall demand for health services.

There are increasing concerns about this growing shortage in the overall supply of nurses, including in rural and remote areas.

The Commonwealth Government estimated that in December 1999 there were shortages in several nursing categories for all States and Territories, including operating theatre and critical/intensive care nurses. For most States and Territories there were also shortages of accident/emergency, aged care, mental health, midwifery and general Registered Nurses. Although these data are not specific to particular areas, the report indicates that there were generally shortages of these types of nurses in both metropolitan and regional areas (AIHW 2000).

Workforce modelling in NSW has revealed an increasing gap between requirements and supply of a wide range of nursing specialties in rural and remote areas in NSW (NSW 1998).

Rural nurses believe that aged care is seen as a poor relation by many nurses and, apparently, by policy makers as well, so that the supply of nurses for aged care in remote and rural areas is badly affected when there is an overall shortage of nurses in these areas. This situation is exacerbated by the 20% higher incomes (up to $130 per week) available to hospital-employed nurses compared with those working in aged care (ANHECA 2001, ANF 2001b).

The ANF has recently argued that the nationwide shortage of aged care nurses "has rendered the Federal Government's nursing home accreditation system unsustainable". The system has no processes for checking whether nursing rosters are or can be filled in the future. The Tasmanian State Department reports an estimated current shortage of between 100 and 150 aged care nurses in the State and, according to the Hobart Mercury, if more cannot be attracted and retained, "the provision of aged care services in Tasmania will collapse" (quoted in ANF 2001c). The AMA has strongly supported calls for better wages for nurses working in private residential aged care facilities (AMA 2001) and Aged and Community Services Australia has agreed that wages are a problem but that Government funding levels are to blame, not the operators of the facilities (ACSA 2001).

In rural and remote areas the special problems of isolation, extreme staff shortages and small facilities exacerbate the more general problems for nursing in the aged care sector. For example, staff shortages exacerbated by the administrative burden of accreditation processes and requirements increase burnout rates for aged care nurses, especially those in management/administrative positions.

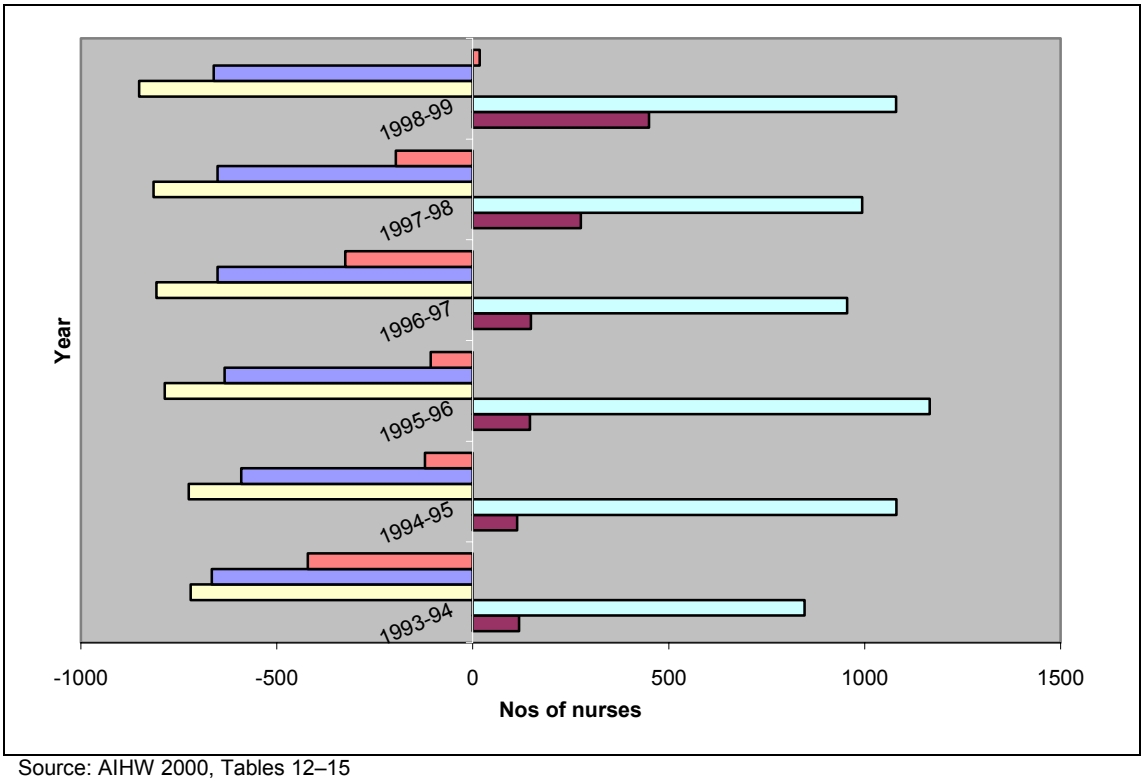
F2 Impact of migration

The universal need for nurses has meant that one of the benefits of being a nurse is the opportunity it provides to travel and work in different countries. Australia benefits in two ways from this. Australian nurses returning to Australia after a period overseas bring extra experience and skills. Australia also benefits from nurses from other countries spending time in Australia and contributing their skills to the Australian health care system. Furthermore, some overseas trained nurses settle in Australia, contributing their skills over an extended period.

Depending on the flow of temporary and permanent migrants, one of the potential downsides of this is that some countries are disadvantaged if they experience a net outflow of nurses. Figure 4 shows that until recently Australia has had net outflows from migration.

In 1998–99 there was a net inflow into Australia of 419 nurse permanent migrants. This potential increase in the nursing workforce was almost exactly offset by a net outflow of 401 nurses working here or leaving here temporarily. 1998–99 is the only year over the period 1993–94 to 1998–99 when there has been a net increase in nurses in Australia from migration flows (AIHW 2000). This appears to be mainly attributable to a steady rise in the numbers of nurses coming into Australia to work temporarily, from 118 in 1993–94 to 450 in 1998–99.

Figure 4 Flows of nurses to and from Australia 1993–94 to 1998–99



Source: AIHW 2000, Tables 12–15

F3 Distribution

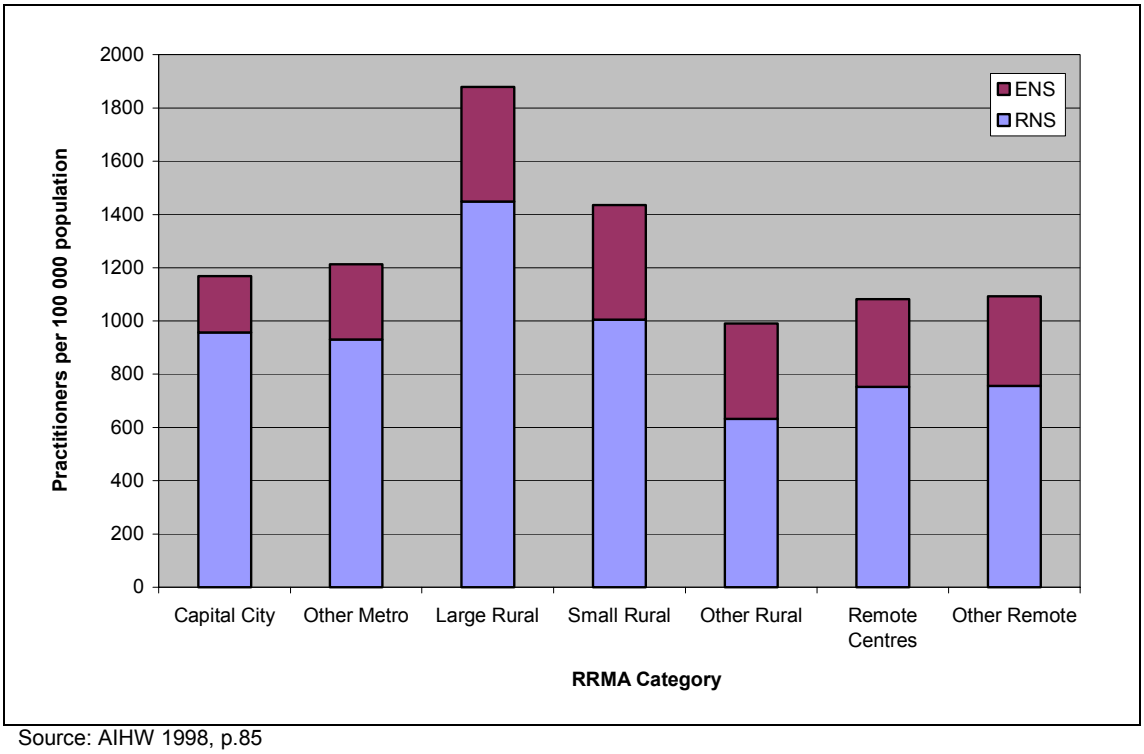
The ratio of nurses to overall population is similar for capital cities and other areas (AIHW 2001, Table 1). The nursing workforce in non-capital cities was 70 252 or 1037.8 per 100 000 population, compared with 1 072.9 per 100 000 in capital cities. These figures include all nursing occupational groups.

Data from the same study demonstrate that the nursing workforce was more evenly distributed between capital cities and rural and remote areas than any other health occupations, with the exception of 'other health workers', a small group covering a range of occupations (AIHW 2000, Table 1).

The distribution of rural nurses between States broadly reflects the related regional State populations (Stephenson, Blue and Petrov 1999).

When the distribution of Registered and Enrolled Nurses is examined using the RRMA classification, the 'large rural' and 'small rural' areas have the highest ratio of nurses to population. Remote areas have nursing ratios similar to those in capital cities and other metropolitan areas (Figure 5).

Figure 5 Geographic distribution of nurses 1995



Source: AIHW 1998, p.85

The AIHW attributes the relatively high numbers of nurses in large rural centres to the relatively high proportion of hospital beds in these areas which also serve remoter areas (AIHW 1998).

F4 Characteristics of the rural nursing workforce

Several sources have been used for the material in this section. The data are usually based on surveys and at times are not consistent between different sources. Despite this, a pattern does emerge from the data.

Over 90% of rural nurses are female, a similar proportion to that applying in the total nursing workforce (Stephenson, Blue and Petrov 1999) .

The overall nursing workforce is concentrated in age groups up to 45 years, with 69.1% of the total nursing workforce being aged 44 years or less (AIHW 2001).

There is evidence that the regional nursing workforce, at least within some cohorts, has an older age profile. For example:

- rural hospital nurses aged over 50 years were found to be more likely to be working in 'rural other' areas (Hegney, Pearson and McCarthy 1997);

- a survey in 1998 of members of the Association for Australian Rural Nurses found that around 63% of those participating were aged 45 years or older (AARN 1998);

- a 1998 survey of Registered and Enrolled Nurses working in rural Australia found they had an average age of around 43 years (Stephenson, Blue and Petrov 1999);

- the Commonwealth Department of Health and Aged Care states that the remote and rural nursing population is ageing with an average age of 38 years and with 35% of remote and rural nurses being over the age of 45 years (DHAC 2001); and

- ageing of the rural nursing workforce was identified as an issue at a rural and remote nursing summit in NSW (NSW Health Department 1998).

Best characterised the nursing workforce in small rural towns as

> "either:
>
> - young and generally transient, or
>
> - older, mostly trained in the era before university training was available and often married to a farmer." (Best 2000 p. 93)

(This last point is reflected in the ancient aphorism that the safest way for a farmer to diversify their business was to marry a nurse.)

Ageing is also an important issue because the physical nature of some clinical nursing work means that nurses may retire earlier than the general working population.

0.8% of the nursing workforce is Indigenous, identical to the overall proportion employed in health occupations. Within nursing categories there is considerable variation in the proportion who are Indigenous. Indigenous people are concentrated in the lower level nursing occupations. Specifically Indigenous people comprise:

- 0.2% of directors of nursing and nurse managers;
- 0.2% of Registered midwives;
- 0.5% of Registered Nurses;
- 1.3% of nursing assistants and personal care assistants; and
- 2.3% of Enrolled Nurses (AIHW 2001).

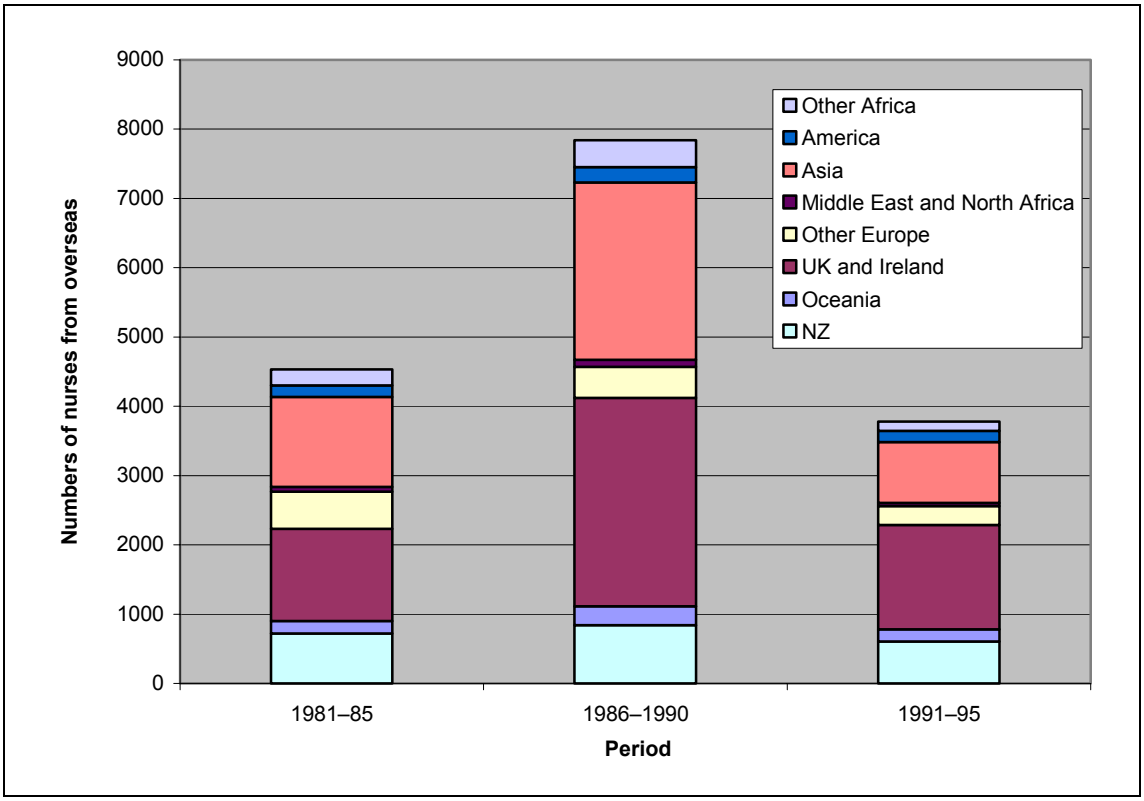
Almost 40 000 nursing professionals in 1996 were born overseas. Of these:

- 42.3% were born in the UK or Ireland;
- 22.6% in Asia;
- 12.6% in other Europe; and
- 10.4% in New Zealand (AIHW 2001).

In 1996 for the entire nursing workforce 26.6% were born overseas, as were 25.8% of nursing professionals (defined to include Registered and Enrolled Nurses) (AIHW 2001).

The Alliance has been unable to locate separate figures for place of birth for rural and remote nurses.

Figure 6 Trends in place of origin of Nurses in Australia born overseas



F5 Qualifications of the rural nursing workforce

A Hospital Registered Nurse Certificate remains the dominant qualification for rural Registered Nurses (Stephenson, Blue and Petrov 1999). This is so despite the transfer of Registered Nurse education from hospitals to universities beginning in 1984 (National Review of Nurse Education in the Higher Education Sector — 1994 and Beyond, 1994) and opportunities since then for hospital-trained nurses to upgrade their qualifications.

A 1998 survey found that of rural nurses:

- 81% have generalist qualifications;
- over one third are practising midwives;
- less than 7% have psychiatric qualifications; and
- 14% are Enrolled Nurses (though this figure is low compared with AIHW data below) (Stephenson, Blue and Petrov 1999).

The proportion of nurses who are Registered Nurses generally falls with increasing rurality. As a proportion of Registered and Enrolled Nurses, Registered Nurses comprise:

- 77.8% overall;
- 82% in capital cities;
- 76.8% in other metropolitan areas;
- 77.1% in large rural centres;
- 70% in small rural centres;
- 63.7% in other rural centres;
- 69.4% in remote centres; and
- 69.2% in other remote areas (AIHW 1998).

The increased reliance on Enrolled Nurses in remoter areas raises a number of issues, given the complexities of health problems in remote areas and the limited support available from doctors and other health professionals.

F6 Type of work and hours worked

28.3% of the nursing workforce reported working more than 40 hours per week, 27.6% less than 24 hours per week (excluding those reporting zero hours), though this information is not published for remote and rural areas (AIHW 2001).

Many nurses in remote and rural Australia operate across settings and between different types of care (Stephenson, Blue and Petrov 1999).

Compared with the other major health occupations the nursing workforce is more likely to be employed in the public sector. 48% of the nursing workforce is employed there (AIHW 2001). While these figures are not separately published for remote and rural areas it is likely that this figure is higher in such areas because of the relatively few private hospitals in these areas, major employers of nurses.

Hospitals (61% of rural nurses work there for at least part of their employment), residential aged care facilities (22%) and community health services (18%) account for a high proportion of the workplaces of rural nurses. Despite this, rural nurses are also employed in a wide range of other facilities and roles including correctional services, occupational health, the Defence Force, community and institutional mental health services, community-based aged care and Aboriginal medical services (Stephenson, Blue and Petrov 1999).

Rural nurses trained in metropolitan universities and working in hospitals are more likely to be in larger hospitals (ie those with 51 or more acute beds). This gives rise to concerns that smaller hospitals with an older hospital-trained workforce may find increased difficulties in the future in attracting nursing staff (Hegney, Pearson and McCarthy 1997).

F7 Increasing the supply of nurses in rural and remote areas

> …. there is an imminent nursing workforce problem which some predict will dwarf the lack of doctors in the bush (Best 2000 p.93).

The Alliance believes that effective recruitment and retention of nurses in remote and rural areas is inextricably linked with education and training issues as well as a range of issues about nursing itself. This section deals with recruitment and retention issues, notwithstanding that people's interest in rural nursing as a career will be partly influenced by a range of factors linked to education and training. These factors are addressed later in this submission.

Later sections outline measures which might increase the proportion of nurses willing to work in remote and rural areas. These could be effective to some degree. Nevertheless in the context of a growing under-supply of nurses across Australia, the Alliance considers that increasing the overall supply of nurses in the health workforce in Australia is the only viable long-term route to securing the increased availability of nurses in remote and rural areas.

There is little prospect of attracting substantial numbers of practising nurses away from urban areas while there remain significant shortages of nurses overall, including for urban health settings. Also, with many nursing opportunities available in urban areas, there is a chance that more nurses with rural backgrounds will be attracted away from rural areas than are persuaded to leave urban practice for rural and remote practice.

F8 Increasing the overall supply of nurses in Australia

There are a number of ways in which the total number of practising nurses could potentially be increased. They include:

- increasing the number of undergraduate places;
- increasing completion rates for nursing students;
- reducing losses from nursing at the transition from higher education to work;
- increasing the number of nurses working in Australia from overseas; and
- increasing the average number of years a nurse spends working as a nurse.

Each of these possibilities is discussed briefly below.

F9 Increase the number of nurses from overseas practising in Australia

We have earlier shown that Australia does not have a history of being dependent on a net inflow of nurses from overseas (see D2 above). The Alliance supports the free

movement of nurses to and from Australia as a means of enriching nurses' experience and increasing the attractiveness of nursing as a career.

There are worrying signs, however, that Australia is starting to rely on a net inflow of nurses working temporarily in Australia to meet some of its nursing workforce requirements (AIHW 2000). The Alliance considers that any such strategy should only be for the short-term. We believe that a preferred approach is to establish ongoing strategies to make Australia self-sufficient in its nursing requirements, in the context of a minimal net flow of nurses moving between Australia and other countries. Adopting our recommendations in this submission would go a long way to achieving this.

Recommendation 13

Nursing organisations and employers should be consulted about the potential for collaborative professional activities in international forums, in conjunction with formal governmental promotions and communication, to ensure that to the extent that there is a future increase of internal and external migration of nurses, it does not prejudice the supply of nurses in key areas and specialties.

F10 What factors attract people to rural nursing and influence their decisions to remain?

There is a large body of international literature addressing questions about how to attract and retain health professionals to remote and rural areas. Much of this is directed at doctors, but many of the issues and principles relate to nurses and other health professionals as well.

For example Australian research by the Association for Australian Rural Nurses suggests that the factors most commonly identified by rural nurses as essential in influencing their decisions to take up rural nursing were both personal and job-related. This study demonstrated that personal factors included the healthy environment and lifestyle and an affinity with country areas (eg raised in country areas, friends and family in the area). Work factors included variety, experience, career development and diversity (Stephenson, Blue and Petrov 1999). The recent Queensland study (Hegney et al 2001) confirms these factors as being responsible for decisions about whether or not to leave rural and remote nursing in parts of that State.

Attracting nurses to work in remote and rural areas is one thing. Retaining them is quite another. There are often low retention rates for nurses and doctors in remote and rural areas. A report from Central Australia indicated that in some areas the turnover rates were 80% and 110% for doctors and nurses respectively (NRHA 2000). In Queensland the average turnover rate for nurses is 20.2 for permanent nursing staff, but for some remote and rural health districts the rate is much higher (Queensland 1999).

The most important essential factors influencing decisions to remain in rural nursing are friends and family in the area, lifestyle, challenge and variety of the work and job satisfaction (Stephenson, Blue and Petrov 1999). The study identified the two broad classes of factors influencing nurses' decisions to leave rural practice as being job-related and family circumstances. Job-related factors included threat of privatisation, downgrade or closure of the facility, lack of opportunities for continuing professional development and administrative problems. Family circumstance related to such issues as relocation of family, death or illness and other family considerations (Stephenson, Blue and Petrov 1999).

Although it includes a reservation about extending its findings, due to the sample size, the Queensland study by Hegney, Rogers-Clark, Gorman, Baker and McCarthy suggests that the characteristics of rural places, such as size, the local economy, cost of living and distance to the next major town, are not as important as the value and circumstances of the work. It suggests that this "should be seen to be encouraging factors with regard to the attractiveness of rural and remote area communities as places to live and work" (Hegney et al 2001 p.viii).

Other job-related factors include concerns about occupational health and safety such as violence against nurses, especially against those working alone or in remote areas, and dangers from travelling on inadequate roads.

Nurses also raise concerns about poor quality management and inadequate performance management systems[6].

The lack of access to local, high quality education for their children and employment opportunities for spouses are also frequently mentioned by health care professionals as concerns and reasons for leaving rural practice. Similarly the lack of suitable accommodation is another major concern, especially in the more remote areas. These are issues not easily addressed, but which should be tackled as part of the broad approach to sustaining regional, rural and remote communities outlined in a later section of this submission.

Research such as that by Stephenson et al and Hegney et al provides evidence for the basis of targetted recruitment and retention strategies. But it also sounds alarm bells as rural health services and their workforces in general are currently beset by all of the same issues that lead to nurses leaving country practice.

F11 Workforce planning

The nation needs accurate forecasts of the supply and demand for nurses, including by specialty and location, and at national and regional levels. This information would underpin effective policies for the recruitment and retention of nurses.

Even without such precise data it is clear that there are currently inadequate numbers of nursing students graduating, entering and being retained in the nursing workforce to meet the nation's current requirements. This growing problem is linked to inadequate consultation on workforce supply and demand between workforce

[6] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing.*

agencies, universities and the Commonwealth Department of Education, Training and Youth Affairs on workforce supply and demand. Nurses are the largest and most widely dispersed health occupational group and their services are vital on a daily basis to the health system throughout Australia.

The failure at the nexus of nurse education and workforce planning is partly due to the separation of responsibilities between the Commonwealth and the States.

Nursing Education in Australian Universities made a series of recommendations designed to ensure appropriate workforce planning at both State and national levels (National Review of Nurse Education in the Higher Education Sector; Recommendations 8.1 and 8.2). These appear not to have been implemented in any cohesive way.

Recommendation 14

The Review should ask governments to investigate why the national workforce planning mechanisms for nursing recommended in 1994 have not been implemented.

Recommendation 15

That the Review itself identify and recommend to the Federal Government processes and structures that will make workforce planning for nursing more effective and which involve both Commonwealth and State health agencies, employers of nurses, nurse education providers and the Commonwealth Department of Education, Training and Youth Affairs.

Recommendation 16

That closer links be established between structures and processes for nurse workforce planning and those for other health occupations.

Recommendation 17

That, once established, these workforce planning mechanisms should give priority to assessing the nursing workforce needs of remote and rural areas.

F12 A National Framework for the Education, Recruitment and Retention of the Nursing Workforce in Remote and Rural Areas

> New partnerships now need to be formed among governments, businesses and communities, all of whom have to play their part. Community development will not happen without governments, business and community stakeholders each making their contributions towards locally developed plans within a regional context. Communities that have reinvented themselves have identified and capitalised on their natural strengths, resources and self-interests to enhance their environmental assets and generate economic and social development. (Regional Australia Summit Communiqué 2000)

Earlier in this submission the Alliance postulated that reasons for the lack of effective action on previously identified nursing issues include a lack of national leadership, confusion about where responsibility lies for specific aspects of nursing and the lack of effective structures and processes to deal with nursing issues. This section outlines a sensible approach to ensuring a more strategic approach to nursing issues in the future, especially those related to rural and remote areas. In doing that it draws together some of the earlier more specific recommendations.

There have been repeated calls for the Commonwealth to take greater responsibility for nursing issues, especially those related to remote and rural nursing (see most recently NARHERO 2001).

Despite this the Commonwealth remains reluctant to take a major role. Having one level of government responsible for nursing issues would help to encourage a more strategic approach. The existing split in responsibilities complicates any attempt to do this.

For example the States and Territories have responsibility for regulation of nursing, are major funders of the health system and are major employers of nurses through funded public health services. The Commonwealth plays a major rule in influencing university student profiles, is responsible for immigration policies and also provides substantial funding to both public and private health services. It also provides national leadership in Australia's health policies, seeking to achieve improved health for all Australians. In recent years it has begun to fund modest initiatives for remote and rural nurses, which fact is welcomed by the Alliance.

Clearly the nursing workforce is a key one in achieving Australia's health goals. Australia can no longer afford to allow fragmentation and confusion over responsibility for nursing issues to hinder developing and maintaining an effective and appropriately distributed nursing workforce in rural and remote areas.

The Alliance therefore suggests that governments and other key parties agree on effective collaborative arrangements which enable nursing issues to be dealt with in a timely and cohesive manner.

The Commonwealth should have a leadership role and through its responsibilities for higher education, migration and the aged care sector, take responsibility for national workforce planning to ensure a sufficient overall supply of nurses to provide for Australian's health care needs, wherever they are located. This role should also include identifying, promoting and, where appropriate, funding special measures to

encourage increased numbers of young people from remote and rural areas to enter nursing as a career.

The Commonwealth through its leadership role in health policy and its interest in having a flexible and mobile health workforce should also encourage consistent approaches to terminology, role definitions, competencies and educational requirements for nursing in remote and rural areas. Policies on mutual recognition demand a cohesive approach across Australia to these issues.

To perform such roles effectively the Commonwealth Department of Health and Aged Care should have a small, dedicated unit of staff with nursing experience and qualifications, including some with experience in remote and rural areas. This unit would give the Commonwealth the credibility to influence other players and the resources to pursue these issues with vigour. Ideally the unit would be headed by a Director of Nursing Policy (or Chief Nursing Policy Officer), with sufficient status to be able to play a significant role in the Commonwealth's broader health policies and to influence the Department of Education, Training and Youth Affairs in its approaches to workforce planning for nurses.

State and Territory Governments would retain their responsibilities for the registration and regulation of nursing and for coordinating State nurse workforce planning and broader nursing policies across their jurisdictions. They must ensure that the legal and regulatory framework governing nurses working in rural and remote areas:

- legitimises the actual roles of such nurses both as practised currently and emerging for the future;
- ensures protection for nurses providing such services; and
- ensures protection for communities from inadequately trained nurses being employed in such roles.

Universities and other organisations responsible for the education and training of nurses must ensure the continued relevance of their programs for nurses planning to work (or working) in remote and rural areas. This will involve cooperative arrangements with employers to ensure that programs are in tune with the demands on nurses from contemporary remote and rural health care practice. They should also strengthen their activities to encourage and support nursing students from remote and rural areas.

Employers of nurses, whether in the public sector, the private sector or non-government organisations, should be responsible for ensuring adequate staffing, both in terms of numbers and ongoing competence. To do this, attractive employment packages must be available, tailored to meet the circumstances of particular locations.

Such employers have a vested interest in maintaining the future supply of well-trained remote and rural nurses. Therefore they should make every effort to find ways to accept student nurses at their facilities.

Local governments and communities should engage themselves actively with universities and employers to see how they can contribute to reducing barriers to

achieving and maintaining a competent remote and rural nursing workforce. This might include help with accommodation, funding scholarships or schools career programs, providing support for student nurses living away from home and for nurses employed in their areas, dealing with violence and examining ways to share resources such as transport, IT and support staff across different services.

Recommendation 18

That all stakeholders, including Commonwealth, State and Territory Government agencies, remote and rural health services, nursing organisations, nursing education bodies and rural and remote communities collaborate to find effective means to attract and retain a sufficient number of appropriately trained nurses working in remote and rural areas within an agreed national framework along the following lines:

- the Commonwealth Government to play a lead role in nurse workforce planning and remote and rural nursing issues with national implications (eg those affecting mutual recognition and workforce mobility);
- State and Territory governments to ensure that appropriate legal and regulatory frameworks are in place and to coordinate nursing policies and workforce planning across their jurisdictions;
- all jurisdictions to ensure direct program funding reflects the health needs and real costs of providing services in remote and rural areas, including costs of realistic employment packages for nurses and costs related to nurse education and ongoing skills maintenance and development;
- local governments, employers and nursing organisations work with universities in areas such as increasing the numbers of remote and rural nursing students and ensuring the continued relevance of their programs for nurses in remote and rural areas; and
- local governments and communities to explore all possible avenues for them to become actively involved in recruiting and supporting rural and remote nurses.

Finally the Alliance emphasises the importance of rural and remote nursing issues being set in a wider context. We believe that nursing workforce issues, along with other health workforce issues, will not be fully resolved in isolation from a broader strategic long-term approach to sustaining regional, rural and rural communities. Such an approach would involve all facets of government, industry and communities in, for example:

- creating an economic climate to rejuvenate regional Australia;
- changes in taxation;

- a major emphasis on land care; and
- major investments in infrastructure and social and human resource capital development. (NRHA 2001b, Garlick 2000).

Recommendation 19

That all health policy be based on a social model of health which addresses the broad determinants of health and is driven by a whole of government approach. Other determinants of health, such as environmental degradation and the sustainability of natural resources, should be urgently considered in the planning and allocation of resources for health.

Recommendation 20

Rural development has to be recognised as a health issue. Without it there are declining communities, with little sense of direction, an uncertain future and poorly motivated leaders. These result in poor health directly through the stress, frustration, and alienation that people feel. They also result in poor health indirectly through the difficulty for governments and the private sector of providing health services to areas that have small, sparse or declining populations. (NRHA 1998)

F13 Attracting people to nursing courses who are more likely to take up practice in remote and rural areas

A high proportion of nurses working in remote and rural areas have strong rural backgrounds or connections. Yet the overall participation rates for students from rural and remote backgrounds in higher education are low. 26.6% of metropolitan young people aged 19–21 years are university students. The equivalent figures for rural, rural/remote and remote areas are 20.6%, 15.8% and 9.6% respectively (DETYA 1999b).

This suggests that special efforts should be made to encourage young people from rural and remote backgrounds to undertake undergraduate nurse training, if a real impact is to be made on overcoming the worsening shortage of nurses in remote and rural areas. (These figures also demonstrate the fundamental importance of increasing the levels of education and training for young people from remoter areas).

This will require a strategic approach with short, medium and longer term projects. For example one report found that factors such as educational aspirations, level of access and socio-economic status are only of limited importance in explaining variations in university participation rates in non-metropolitan areas, unlike in

metropolitan areas where these factors are very significant. The authors concluded that:

> …community attitudes to education would need to change fundamentally before university participation rates in non-metropolitan areas would approach those of metropolitan areas (DETYA 2001 p.2).

This suggests that a key longer term strategy to increase university participation rates amongst rural residents would be community education programs about the value of higher education. The increasing focus on rural communities solving their own problems will add impetus to the importance of increasing the proportion of the population with higher education.

Research findings are emerging which help chart the way for closer collaboration between university campuses and the regions in which they are located. The benefits of such collaboration include enhanced economic development and human and social capital (DETYA 2000). There may be scope for universities in regional areas to collaborate closely with community leaders to find ways of increasing the nursing workforce. One tool which could be useful in guiding this work is *Atlas of Higher Education: a community focus* (DETYA 2001).

Some universities already have special programs in place to attract and support students from rural and remote areas (and other under-represented groups). For example the University of South Australia has its University's Special Access Scheme to increase the access, participation and support to educationally disadvantaged students, including those from rural and remote areas. Though not specific to nursing, the scheme is reported to be successful in leading to an increase in the proportions of students enrolling at the university from the targeted schools (Ramsay et al 1998).

Given the key importance of increasing the nursing workforce in remote and rural areas and the generally relatively low socio-economic status of people living in these areas, financial considerations are important (Heaney 2000). While there are many benefits of the change in nurse education from hospitals to universities, one possible downside, especially for students from lower socio-economic backgrounds, is that hospital-based student nurses received a wage, while undergraduates incur considerable costs.

> Changing from hospital training to tertiary training: while I am in favour of the change for reasons of superior training, professional recognition etc, there are economic pressures that have not been addressed. I was trained in the hospital system and the big attraction was that I would be earning money as I trained. I don't know that the training would be as attractive now — particularly when the rewards after graduation are not necessarily that appealing in comparison to most other professions. (C. Wilson 2001)[7]

The Higher Education Contribution Scheme (HECS), which requires university students to contribute to the costs of their courses, is said to be a major barrier to potential nursing students, especially those from lower socio-economic status groups.

[7] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing.*

HECS contributions for nurses are currently $3 521 per annum (DETYA 2001b). This is less than the contributions for other health programs; for example medicine is $5 870 and for most others it is $5 015. Registered Nurses, however, have lower income expectations than many other graduates. The median starting salary for newly-graduated Registered Nurses in 1998 was $30 000 including shift allowances, per annum. This compares with:

- $34 000 for physiotherapists;
- $33 700 for speech pathologists;
- $33 000 for occupational therapists;
- $40 000 for optometrists;
- $24 000 for pharmacists;
- $32 300 for veterinarians; and
- $43 100 for doctors (GCCA 1999a).

Discounts on the HECS charges are available to those students willing and able to pay in advance (DETYA 2001b). However students from remote and rural areas are often unlikely to have funds to be able to do this.

Thus it is understandable that concerns about HECS liabilities are major ones for many young rural and remote people contemplating higher education.

A range of ideas has been suggested to provide incentives through HECS variations for students to take up nursing courses. These include:

- waiving of HECS fees for nursing students;
- waiving HECS fees for nursing students from remote and rural backgrounds; and
- forgiving HECS debt for nursing students who undertake a specified period of nursing in rural or remote areas.

The Alliance accepts that providing special HECS arrangements for nursing students would create precedents for the Government for other fields of study. Given the special circumstances of nursing, including the developing crisis in shortages of rural and remote nursing numbers, the relatively low earning capacity of nurses and the predominantly female composition of the nursing workforce, the Alliance believes that an exception should be made, at least for those taking up rural or remote nursing.

Recommendation 21

That the Review identify, for the Government's consideration, innovative approaches to reduce the burden of HECS on nurses practising or intending to practise in remote or rural areas. On balance, approaches which reward nurses who actually practise in rural and remote areas are preferred, such as forgiving HECS debts for such nurses.

One approach could be for HECS debts for nurses who indicate a willingness to work in designated remote and rural areas to be frozen for ten years. If, during that ten year period, a nurse practised in any of these designated areas, one year of HECS debt would be written off for each year of full-time equivalent nursing employment. The flexibility offered by the ten year period of grace would enable nurses to practise in urban areas or do further training to gain greater expertise and confidence before taking up a rural or remote nursing post.

Increasing other forms of financial assistance, for example bonded and non-bonded scholarships and assistance for remote area students to attend careers promotions activities, would also encourage higher participation rates for remote and rural young people in nursing courses. The postgraduate rural and remote nursing scholarships currently funded by the Federal Government are already working well in this latter regard and beginning to tap the lode of demand for support that exists in this area.

'Money' is one of the 3Ms identified as constituting the major barriers to more young people from remote and rural areas entering the health professions, including nursing (Heaney 2000). 'Marks' and 'Motivation' are the other two. Heaney advocates a range of measures designed to overcome these barriers including suggestions about:

- entry requirements for rural and remote students wishing to enter health care courses;
- enhanced educational opportunities, including health care work experience placements;
- early identification and fostering of potential health care professionals; and
- enhanced health careers activities in remote and rural areas.

Recommendation 22

That Health and Education Departments and schools collaborate closely with local governments, universities, other health education and training bodies and local government to put in place programs with potential for short, medium and longer term impacts to encourage more young people from rural and remote areas to undertake undergraduate nursing courses, including:

- increased numbers of Commonwealth funded scholarships for students from remote and rural areas who are nursing students so that the numbers of nursing scholarships are pro rata equivalent to Commonwealth funded scholarships for medical students;
- HECS concessions as indicated in Recommendation 21;
- Commonwealth funded incentives for universities to implement programs to encourage students into nursing courses from rural backgrounds, building on the experience of such funding for rural medical students and the experiences of universities with successful access and participation programs for rural and remote students;

- careers promotion, information programs and use of role models to encourage an interest in rural and remote nursing as a career;
- popular radio and TV programs which present positive images of rural and remote nurses;
- research to see whether it is possible to attract more rural young men into nursing and if so the development of programs based on the results to achieve this;
- community education programs to increase understanding and acceptance in rural and remote communities about the value of higher education for local young people and their communities; and
- university campuses and community leaders in regional areas with nursing shortages identify this as a priority for collaborative activities focused on enhancing regional development, and human and social capital.

Implementing Recommendations 21 and 22 along with more targeted ones to increase the attractiveness of rural and remote nursing opportunities as suggested in G2 could make a big impact on the availability of nurses in rural and remote areas and thus on the health of the residents of remote and rural Australia.

F14 Increasing the number of Aboriginal and Torres Strait Islander People entering the nursing workforce

Special arrangements are necessary to recruit and retain Aboriginal and Torres Strait Islanders into nursing programs.

There is a higher proportion of Aboriginal and Torres Strait Islander people living in remote and rural areas than in other regions (AIHW 1998). They also provide a higher than expected number of Enrolled Nurses (AIHW 2001).

Increasing the numbers of Aboriginal and Torres Strait Islander people from remote and rural areas who enter nursing would help achieve several objectives. It would contribute to the nursing workforce in these areas, provide employment opportunities for people from Aboriginal and Torres Strait Islander communities and increase the nursing workforce's understanding of Aboriginal and Torres Strait Islander cultural and health issues. All of these factors would lead to improved health for the group with the poorest health in Australia.

Major challenges must be faced before any substantial impact is likely on the numbers of Aboriginal and Torres Strait Islander people entering the nursing workforce. These relate, for example, to:

- cultural issues generally and in relation to curricula (AIHWJ, 1999);

- lack of suitable bridging courses and acknowledgment of prior learning;
- inappropriate selection criteria and interview processes;
- lack of acknowledgment of experience and knowledge in Indigenous health in career structures;
- insufficient support within universities for Aboriginal and Torres Strait Islander nursing students;
- lack of articulation between nursing and Aboriginal Health Worker qualifications;
- lack of distance learning opportunities to enable students to remain in their communities while undertaking nursing programs (CATSIN 1997).

The Council of Aboriginal and Torres Strait Islander Nurses has adopted a range of recommendations for nursing to address these and other issues covering:

- cultural heritage and identity;
- professional nursing issues;
- recruitment and retention of Aboriginal and Torres Strait Islander nursing students;
- nursing education; and
- the relationship between the roles of Aboriginal Health Workers and the Aboriginal and Torres Strait Islander Registered Nurse.

The Alliance considers that these recommendations form an excellent basis for future action to make a nursing career more attractive and appropriate to Aboriginal and Torres Strait Islander people. We believe that if the relevant parties adopt these recommendations the result will be a greater participation in the nursing workforce by Aboriginal and Torres Strait Islanders and a more appropriate health system, particularly in remote and rural areas. We commend them to the Inquiry. These recommendations are at Appendix 2.

Recommendation 23

That the Review use the recommendations of the Council of Aboriginal and Torres Straight Islander Peoples developed from the 1997 Aboriginal and Torres Straight Islander Nursing Forum (Appendix 2) as a basis for its own recommendations on issues related to nursing and Aboriginal and Torres Strait Islanders, noting that some of the recommendations would directly benefit nurse education and training for all nursing students and the future careers of all nurses.

Section G Models of nurse education to meet the needs of the emerging workforce

G1 Registered Nurses

The Alliance strongly supports the retention of university-based education for Registered Nurses at the Australian Qualification Framework (AQF) Bachelor level.

However we believe there is considerable room for improvement in the undergraduate programs in terms of the preparation of nurses for rural and remote practice.

A range of issues have been identified which limit the effectiveness of nurse undergraduate programs as preparation for rural and remote practice. These include:

- insufficient clinical experience, a special problem for nurses in rural and remote areas who have less support and back-up than their urban counterparts;
- limited or no rural or remote experience on the part of teaching staff;
- insufficient content on Indigenous health and rural and remote cultural sensitivity and cultural safety;
- inadequate funding and accommodation for rural and remote placements; and
- insufficient recognition of and action to resolve the extra load placed on rural and remote health services from accepting student nurses. Such services are already very stretched and it is difficult for them to provide appropriate supervision and training without funding for relief staff.

The Alliance considers that universities should urgently address these problems to ensure their undergraduate nursing programs are suitable for those wishing to enter remote and rural practice.

Recommendation 24

That universities with bachelor programs in nursing should urgently examine the curricula, teaching methods and the composition of their teaching staff to ensure their programs are suitable for and encouraging of remote and rural nursing practice. In particular they should ensure that:

- the programs meet a national minimum standard of content of Aboriginal and Torres Strait islander heath, culture and cultural safety;
- all students have the opportunity for clinical placements in remote or rural health services; and
- teaching staff include a good representation of nurses who have had substantial experience practising in remote and/or rural areas.

Recommendation 25

The maintenance of high quality health services in rural and remote Australia is contingent upon the continuing development of flexible education and training programs that are locally, culturally and socially appropriate. Undergraduate curricula for all health disciplines should include health promotion, primary health care, population health and cultural safety components. (Note: this recommendation is one of the priority fifteen from the 6th National Rural Health Conference)

Increasing the number of clinical placements presents particular challenges. We referred earlier to the difficulties already experienced in obtaining sufficient suitable placements in remote and rural areas. Even where places are available, there are not necessarily sufficient students able or willing to accept them. For example, the Queensland University of Technology has had serious under-utilisation of its available placements in remote and rural Australia. The reasons for this limited uptake are unknown, but thought to be due to lack of financial support to re-locate rather than lack of interest (Best 2000).

This is particularly serious because experience in a rural and remote health setting is thought to be a factor in influencing nurses to take up jobs in such areas. Recent research confirms that this may be the case (Edwards et al 2001).

> One of the main obstacles to training more nurses is the lack of available clinical placements. Small hospitals and even base hospitals in NSW are finding it increasingly difficult to accommodate student nurses on clinical practicums. Dubbo Base Hospital has this year (2001) ceased all High School work experience placements — not just for nursing and other professional health practicums but also for such work as kitchen hands and catering. The reason given is that the overstretched staff are only just coping with their work demands and cannot stretch to accommodate a student in the work place. [8]

Recommendation 26

That universities, remote and rural health services, nursing organisations and governments collaborate to identify and remove barriers to nursing students being able to have appropriate placement in remote and rural health services.

[8] Input provided to the National Rural Alliance's *Submission to the Senate Community Affairs References Committee Inquiry into Nursing*

G2 Enrolled Nurses

> Enrolled Nurses are an integral part of the nursing profession (ANF 2000).

Enrolled Nurses are important both for their role and as a source of supply for people who choose to pursue further study and to graduate as Registered Nurses

In recent years the numbers of Enrolled Nurses have declined (AIHW 2000). One of the reasons for this is that the salary levels of experienced Enrolled Nurses are similar to those of a first year Registered Nurse, so that employers are preferring those nurses with a longer academic preparation (Bell 1998).

The highest proportions of Enrolled Nurses are in rural and remote areas. It is important that they have opportunities to upgrade their qualifications. Bridging programs, involving collaboration between a university and the Technical and Further Education Sector in rural areas, and through distance education, have been successful in giving Enrolled Nurses advanced standing for Bachelor of Nursing programs, allowing then to enter directly into the second year (Bell 1998).

Recommendation 27

That there be wide availability of suitable bridging programs which enable Enrolled Nurses in remote and rural areas to achieve advanced standing in Bachelor of Nursing Programs.

Issues relating to the education preparation for Enrolled Nurses are similar to those for other nurses. They include:

- national consistency to facilitate mutual recognition and ensure the National Competency Standards for Enrolled Nurses are met;
- wide availability of pre-enrolment education courses in all States and Territories;
- education programs should include both theory and clinical practice and use a range of delivery modes including distance education and part-time study;
- implementation of formal articulation and recognition of prior learning between courses for:
  - Enrolled Nurses (Certificate IV) and Registered Nurses;
  - Assistants in Nursing (however termed) (Certificate III) and Enrolled Nurses; and
  - Enrolled Nurses and Aboriginal and Torres Strait Islander Health Workers; and

- wide availability of post enrolment education for Enrolled Nurses to enable career development (ANF 2000).

Recommendation 28

That nursing organisations, nurse regulatory authorities and education providers cooperate to ensure that Enrolled Nurse programs are nationally consistent, widely available and meet national competency standards within a system of recognition of prior learning and formal articulation.

G3 Postgraduate training

Many rural nurses are reported to have a range of qualifications at the diploma or certificate level in addition to their first general nursing qualification. These qualifications cover a wide range of fields, with midwifery being the most common one. Next in frequency were accident and emergency, administration and management, general nursing, geriatric/gerontology, palliative care and counselling (Stephenson, Blue and Petrov 1999).

The same study identified a different pattern of future training needs specified by rural nurses. Ranked by decreasing frequency the most commonly mentioned future requirements were administration and management, accident and emergency, palliative care, rural or remote practice, community health, counselling and geriatric/gerontology.

Nurses in remote and rural areas undertake a comprehensive range of procedures for which they do not have the appropriate legislated qualification or training. A 1998 survey found that around 35% of rural nurses had performed such procedures, though not necessarily recently (Stephenson, Blue and Petrov 1999).

Planning for future continuing professional development and skills maintenance programs for remote and rural nurses must take account of the needs, characteristics, existing qualifications and locations of rural and remote nurses described earlier. In particular:

- time pressures, as many nurses are employed part-time while others have very heavy workloads;
- the age structure;
- the dispersion and remoteness of the nursing workforce and associated problems of relief;
- the relatively high proportions of Enrolled Nurses with higher than average proportions of Indigenous people;
- the relatively high proportions of nurses whose qualification is a hospital Registered Nurse Certificate; and
- the expressed needs of these nurses and emerging approaches to health care.

Barriers to nurses achieving postgraduate qualifications include:

- fees for postgraduate courses highly relevant to rural and remote health care, for example midwifery and mental health, are prohibitive for nurses who still carry HECS debts and who do not necessarily receive higher remuneration in recognition of postgraduate training;
- difficulty in accessing such courses for nurses in remote and rural areas, compounded by high workloads and the inconveniences of shift work; and
- the lack of a tradition of nurses acquiring higher level qualifications.

Recommendation 29

That universities, Rural Health Training Units, other training providers, nursing employers and nursing organisation collaborate to provide readily accessible modular post-basic training programs devised around the personal and professional needs of remote and rural area nurses and which use a variety of innovative delivery methods to ensure ready access for those working outside main centres.

Recommendation 30

That nurses working or intending to work in remote and rural areas be encouraged to undertake appropriate postgraduate preparation.

Recommendation 31

That rural health services and governments assist nurses to undertake appropriate post graduate preparation through the provision of scholarships and/or paid study leave.

Recommendation 32

That curricula for postgraduate programs in each of remote and rural nursing:

- reflect the differences between remote and rural area practice, while containing a substantial common core content;
- are available at the three levels of graduate certificate, graduate diploma and masters; and

- are sufficiently consistent nationally to enable mobility and flexibility of the nursing workforce and economies in curriculum development, while permitting flexibility to meet local needs.

Recommendation 33

That postgraduate programs for rural and remote area nurses be designed using the following guidelines:

- integration between clinical and theoretical components;
- involvement of credible, experienced rural and remote area nurses;
- articulation, flexibility in access and delivery, recognition of prior learning, use of adult learning principles;
- affirmative action for minority and disadvantaged groups;
- the use of clinical preceptors;
- sufficient resources and affordability to ensure sustainability;
- regular evaluation including an assessment of their impact on workforce issues such as work performance and recruitment and retention rates; and
- delivery processes which are collaborative, multidisciplinary and tailored to the needs of the specialty, services and the learner.

Section H Types of skills and knowledge required to meet changing needs

H1 Ongoing professional development and skill maintenance

Some of the ongoing professional and skills maintenance needs of nurses require formal postgraduate programs at graduate certificate, graduate diploma, masters or doctorate level.

In 1999, 1 798 nurses commenced postgraduate courses. This is a ratio of 1 commencing postgraduate student to every 2.7 commencing undergraduate students.

Comparative ratios for other health professionals are shown in Table 2.

Table 2 Comparative rates of postgraduate course commencements between health occupations

Health occupation	Ratio of undergraduate course commencement to postgraduate course commencement, 1999
Nursing	2.7
Medicine and medical science	1.4
Dentistry, Dental Services	2.8
Optometry, optical technology	1.8
Community/Family/Personal Health Care	1.8
Health Science overall	2.3

Source: derived from DETYA 2000, Table 47

These comparisons suggest that, in general, nurses are less likely than their health professional counterparts to enrol in postgraduate programs. These figures must be interpreted carefully as the nursing undergraduate figures include nurses upgrading their qualifications from a hospital certificate to a bachelor degree. Such upgrades are important in the context of a relatively new discipline taught in higher education institutions and the growing complexity of nursing knowledge and skills. Achieving this would be threatened by relatively low participation by nurses in formal postgraduate programs.

Further, given the increasing complexity of health care and the specialisation that it tends to bring, there will be an increasing need for practising nurses to acquire postgraduate qualifications. Many nursing organisations consider that remote and rural nursing is a specialty in its own right and nurses should have postgraduate qualifications to enable them to practise safely and effectively.

Barriers to nurses achieving postgraduate qualifications include:

- fees for postgraduate courses highly relevant to rural and remote health care, for example midwifery and mental health, are prohibitive for nurses who still carry HECS debts and who do not necessarily receive higher remuneration in recognition of postgraduate training;

- difficulty in accessing such courses for nurses in remote and rural areas, compounded by high workloads and the inconveniences of shift work; and

- the lack of a tradition of nurses acquiring higher level qualifications.

Furthermore, postgraduate programs do not always meet the learning requirements of mature nurses or offer appropriate recognition for previous education and experience.

Recommendation 34

That postgraduate programs for rural and remote area nurses be based on national competency standards for each of remote and rural practice which define the requirements for these two advanced levels of practice and which are validated against practice.

Section I Mechanisms for attracting new recruits

I1 Rural scholarships - Registered Nurses

A system of remote and rural health placements is one mechanism for encouraging nurses to practise in such areas. There are of course others. Many universities have in recent years established undergraduate rural health clubs as a means to interest health students in a career in remote and rural Australia. These clubs arrange various activities to encourage more future health graduates to enter remote and rural health practice and to support those considering such a move. We consider that there is considerable scope for these clubs to present a positive image of rural nursing.

Recommendation 35

That rural undergraduate health clubs place a special focus in their activities on presenting a positive image for rural and remote nursing and encouraging nursing students to spend some time during their careers working in remote and rural areas.

The John Flynn Scholarships Scheme has proved a popular way to enable medical undergraduates to gain some experience working in remote and rural communities and to familiarise themselves with life in one of those communities. The scholarships provide medical undergraduates with a two-week placement once a year for four consecutive years during their medical training. This is in addition to any rural placement that routinely occurs as part of their clinical education.

The Scheme has not yet been established long enough for its impact on the future careers of those involved to be evaluated. Nevertheless, given its positive reception by students and communities alike, the Alliance believes that a similar scheme should be established for student nurses.

Recommendation 36

That the Commonwealth establish a scholarship scheme for student nurses similar to the John Flynn Scholarship Scheme for medical students. When fully operational this Scheme should provide at least 300 scholarships per year for nursing undergraduates.

Section J Changing context of nursing and health requirements

J1 Advanced nursing practice

The National Rural Health Alliance has long advocated for the recognition of advanced practice roles for some nurses in rural and remote Australia, especially those working in remote areas who are already operating at this level. Its work in providing recommendations to the Commonwealth to advance this issue was outlined earlier in Section B. Little if anything has happened through the Commonwealth since then to advance this work.

Further work has occurred on advanced nursing practice in rural and remote areas through the National Association of Rural Health Education and Research Organisations (NARHERO) and the General Practice Partnership Advisory Council (GPPAC), among others. Recommendations from NARHERO's *2000 National Workshop on Advanced Nursing Practice* were outlined in Section B (NARHERO 2001).

A separate but related issue is the question of nurse practitioners. The high levels of autonomy and the wide range of skills and knowledge which apply to many rural and remote nurses mean that there is still a need to recognise the role of the nurse practitioner.

The term 'nurse practitioner' does not yet have a standard definition or scope of practice across Australia. The National Nursing Organisations have an endorsed consensus statement on the recognition of nurse practitioners in Australia which covers definition, scope of practice, educational preparation, career structure, remuneration, protection of title, authorisation to practise and legislative support (NNO 2000).

The term is intended to apply both to specialist nurses (for example those working at an advanced level in a defined field of practice such as women's health, intensive care, operating theatre or accident and emergency) and to rural and remote nurses who are working at an advanced level of practice but whose role is often wide-ranging and flexible, rather than specialty-based.

Emerging developments in the States and Territories suggest that some common features are emerging in the definitions of nurse practitioners and scope of practice descriptions being developed within jurisdictions. For example several jurisdictions include such factors as:

- performing an advanced clinical role including authorisation to prescribe certain medications;

- postgraduate education or other means of demonstrating competence for advanced practice in a specific area of nursing skill; and

- a role for the nursing regulatory authority in authorising nurse practitioners (ANCI 2000).

The General Practice Partnership Advisory Council (GPPAC) has produced discussion papers on both a Framework for Practice Nursing in Australian General Practice (GPPAC 2001a) and, through its Coordination and Research Unit, on the threats ands opportunities for general practice of the roles of practice nurses and nurse practitioners (GPPAC 2001b). It scans the overseas evidence on practice nurses and nurse practitioners and describes the emergence of the role of Nurse Practitioners in this country. (It also makes the point that there are currently no recognised education or training programs for practice nurses, although one is "currently being worked on by the Royal Australian College of General Practitioners and the Royal College of Nursing (Australia)".) All of the States' programs for nurse practitioners prepare Registered Nurses at Masters degree level.

In the wider context of the importance of workforce mobility and the important role played by mutual recognition legislation to underpin mobility, there is a strong case for uniform, or at least consistent, approaches to emerging roles for nurses, the largest single health occupation group. It is time for the Commonwealth to show leadership here.

Recommendation 37

That the Commonwealth Government urgently initiate processes through the Australian Health Ministers' Advisory Council to encourage the States and Territories, key nursing organizations, nurse registration authorities and general practice bodies to negotiate and adopt mutually consistent approaches to advanced nursing practice and 'nurse practitioner' issues in such areas as scope of practice, education and training, career structures, remuneration and legislative underpinning. In undertaking this work there should be recognition of the collaborative models that exist between GPs and nurses in remoter areas and the highest priority should be for remote and rural advanced nursing practice.

Section K Links between nursing, medicine etc and the provision of health services

K1 The broader health workforce picture

> Nurses provide a higher proportion of health care in rural and remote Australia than in metropolitan Australia (AIHW 1998, p. viii).

In remote and rural Australia, nurses are often called upon to do work that might otherwise be undertaken by other health workers such as doctors, pharmacists and allied health workers, if available. The more even distribution of nurses between capital cities and regional areas does not compensate for the poor distribution of these other workforce categories. The ratio of total health workforce per 100 000 residents is 1818.4 in capital cities compared with 1531.6 in other regions (AIHW 2001, Table 1).

In recent years a range of structures has been established in rural areas to contribute towards health workforce planning, education and training and support. These include University Departments of Rural Health, Rural Health Training Units, Rural Clinical Schools, Rural Workforce Agencies, and Divisions of General Practice.

These structures have had a major focus on medical issues, though not exclusively so.

Workforce planning for one health occupational group cannot be undertaken in isolation from planning for others. A particular combination of health care professionals might be seen as ideal, but if the supply of one or more of those occupational groups is not sufficient, alternative provisions have to be made, at least in the short-term. Closer linking of workforce planning across health occupations is covered in Recommendation 16.

Teamwork and collaboration between members of the health workforce is vitally important in remote and rural areas, characterised as they are by shortages of all types of health professionals. This has long been known by health professionals in the field, but there is a greater emphasis on this as the value of teamwork is increasingly recognised for broader reasons. The logic of the full implication of teamwork has not yet flowed through into structures and processes which support clinicians and workforce needs.

Urgent consideration should be given to broadening the roles of rural and remote health training institutions so that they provide comprehensive coverage of workforce issues for all health professionals. For example:

- Rural Workforce Agencies could have a stronger role in their respective jurisdictions in workforce planning across all heath occupational groups;
- Divisions of General Practice could become Divisions of Primary Care; and

- Additional funding could be provided to University Departments of Rural Health and Rural and Remote Health Training Units to further strengthen their inter-disciplinary health workforce activity.

As these refinements would have resource implications, they could first be piloted in a few regions. Changes would build on existing developments such as the formation of the Division of Primary Care in Alice Springs (NRHA 2000).

Recommendation 38

That the Commonwealth provide resources and work collaboratively with the agencies themselves, the States, and professional and community organisations to support a broadened role for agencies such as the Divisions, Rural Workforce Agencies, University Departments of Rural Health, and Rural or Remote Health Training Units. This support would in no way prejudice the autonomy of the agencies and would be designed to allow them more effectively to encompass the needs of all health occupations.

At the undergraduate level, there has been considerable debate about whether or not there should be a common core curriculum across all health sciences, including nursing and medicine (National Review of Nurse Education in the Higher Education Sector 1994). Proponents see this as one way of encouraging team approaches and breaking down inter-professional barriers between health occupations. Opponents are concerned that the integrity of particular disciplines might be lost or one discipline subsumed within another.

A wide range of other issues has been raised in the debate, leading to a recommendation in Nursing Education in Australian Universities: “That funding for demonstration or pilot projects in core curriculum across health sciences, involving nursing, be a priority under the National Priority (Reserve) Fund” (but not medicine).

This issue remains controversial as is evidenced by the debate about whether the proposed new medical school in Canberra should be located at the Australian National University or the University of Canberra with its established health programs. The Alliance considers that it is timely to re-visit this issue, given more recent developments such as the moves to Graduate Medical Programs and a greater recognition of the importance of a holistic approach to health care with an increased attention on primary health care, especially in remote and rural areas.

Recommendation 39

That regional universities be funded to establish pilot programs which have a common core curriculum across all health disciplines, including medicine where the university has or is expecting to have a medical school.

Section L Financing Arrangements

Many of the suggestions and recommendations, in this and earlier sections, will have associated costs. There is evidence to suggest that health resources are not equitably distributed across areas when the higher costs of providing services in remote and rural areas and the lower health status of the population in these areas is taken into account (DHAC and NRHA 2001). In a joint report the Department of Health and Aged Care and the Alliance have called for Governments to consider ways to work cooperatively towards health resource allocations that are more in line with relative need and actual costs of providing services (DHAC and NRHA 2001).

Recommendation 40

The Committee should note the recommendations elsewhere from the Alliance on a '30% fair share' for rural and remote areas, and for examination of alternative funding structures for health services in rural and remote areas to lead to a distribution of health funds that is based more squarely on relative health needs.

The Alliance therefore suggests that all funding agencies should ensure that their funding allocations are adjusted to more accurately reflect health needs and the real costs of providing services in remote and rural areas.

Until this adjustment can be made, dedicated funds should be provided through State/Territory and Commonwealth programs to go directly to providers to enable employers of nurses in remote and rural areas to provide employment packages sufficiently attractive to recruit and retain a competent and sufficient nursing workforce in those areas. Such funding should include the costs of providing appropriate access to education and training programs to maintain and update the skills of nurses and to cover the costs to remote and rural health services of providing training placements for student nurses.

Each jurisdiction should meet its own costs in enhancing its role in nursing workforce issues.

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Appendix 1 Advanced Nursing Practice — NRHA Recommendations to the Commonwealth Department of Health and Aged Care

25 November 1998

The National Rural Health Alliance recommends as follows.

1. That whatever developments there are in relation to Advanced Nursing Practice, whether at national, State or local level, they should be undertaken in collaboration with doctors and other health professionals, and with the community in which the practice is to be undertaken.

2. That the Commonwealth Department of Health and Aged Care accept and advocate for a national framework for the educational preparation and ongoing professional development of nurses practising or wishing to practise at advanced levels in remote and rural areas.

3. That the essential features of this framework are:

    a) national competency standards for each of remote and rural practice which define the requirements for these two advanced levels of practice and which are validated against practice;

    b) frameworks for curricula for postgraduate programs in each of remote and rural nursing which:

        - reflect the differences between remote and rural area practice, while containing a substantial common core content;
        - are designed to reflect the relevant national competency standards;
        - are available at the three levels of graduate certificate, graduate diploma and masters; and
        - are sufficiently consistent nationally to enable mobility and flexibility of the nursing workforce and economies in curriculum development, while permitting flexibility to meet local needs; and

    c) principles and associated guidelines and criteria to govern the development and implementation of programs based on the framework for curricula covering:

        - integration between clinical and theoretical components;
        - involvement of credible, experienced rural and remote area nurses;
        - articulation, flexibility in access and delivery, recognition of prior learning, use of adult learning principles;

- affirmative action for minority and disadvantaged groups;
- the use of clinical preceptors;
- resources and affordability to ensure sustainability;
- regular evaluation including an assessment of their impact on workforce issues such a work performance and recruitment and retention rates; and
- delivery processes which are collaborative, multidisciplinary and tailored to the needs of the specialty, services and the learner.

4. That the Commonwealth Department of Health and Aged Care take the following steps to promote the above national framework:

   a) Fund a collaborative process involving CRANA, AARN, the ANF, CATSIN, employers, experts in curricula development and university requirements, and other relevant parties to:

      - define the principles, guidelines and criteria to underpin the development and implementation of postgraduate programs;
      - develop and maintain frameworks for curricula for graduate certificate, graduate, diploma and masters courses in each of remote and rural area nursing, which promote national consistency while permitting local flexibility and which draw on existing Australian and overseas relevant work;
      - negotiate accreditation and delivery of the model curricula at sufficient academic institutions and delivery sites to ensure national availability and ease of access while ensuring economic viability of the programs;
      - validate the UNE competencies for remote area nurses, once developed;
      - develop competencies for rural nurses drawing, where appropriate, on the existing competencies for the advanced nurse and other nursing specialties and the competencies for remote area nurses currently under development.

   b) Fund scholarships and/or training positions for rural and remote area nurses to undertake programs based on the national framework.

   c) Facilitate processes involving, as appropriate, nurse registration authorities, the RCNA, nursing employers and nursing organisations representing rural and/or remote area nurses to:

- define the relationships for remote and rural area nurses between different levels of educational attainment and categories of nursing as defined by the National Nursing Organisations;

- consider the specific workforce requirements for each of the different categories of remote and rural area nurses and related issues such as career structures and employment conditions; and

- further consider issues related to possibilities in the future for:

  - professional accreditation of postgraduate courses for remote and rural area nurses; and

  - the credentialling and recredentialling of nurses

  This work should take into account all relevant current developments including wider public policies such as those relating to national competition and mutual recognition.

5. That in implementing the above recommendations, the Commonwealth Department of Health and Aged Care take into account:

   a) advice from an advisory group comprising the NRHA Working Party on Advanced Nursing Practice and one representative each from RCNA, the State registration authorities, the Council of the Deans of Nursing and the Chief Nursing Officers; and

   b) the recommendations of the McMurray report and the responses to that report from key stakeholders.

Note: Our thanks to RHSET, Member Bodies of the Alliance, Professor Anne McMurray, and all of the other organisations that have contributed to this work.

Sue Wade, Convenor
Working Group on Advanced Nursing Practice
25 November 1998

Appendix 2 National Aboriginal and Torres Strait Islander Nursing Forum, Sydney, August 1997

Recommendations

Cultural Heritage and Identity

> If you know where you're coming from then you wouldn't have to ask me who the hell I think I am. (Bob Marley)

We are Aboriginal and Torres Strait Islander Peoples before we are nurses. We are first nations people and intend to maintain our cultural heritage.

We recognise that we are on a lifelong journey with cultural obligations and commitment of our communities.

We challenge the western health model in which nurses live and work, as this model promotes separation, hierarchy and power struggles; it denies the emotional, social, spiritual and political aspects of health in our holistic way.

The philosophy that promotes all peoples as equal, or to be treated the same, denies difference and cultural identity. Justice and recognition of Aboriginal and Torres Strait Islander history is a requirement for reconciliation.

All faculties of nursing need to re-examine their models, nursing philosophy and nursing practice. We are the experts in our own health and believe our experience and world view challenges these models. Non-indigenous nurses can learn and benefit from our experience.

Many Aboriginal and Torres Strait Islander nurses are forced to live a 'double life'. This living between two worlds and two cultures causes internal conflict. We see this as a continuation of the assimilation process and support all measures to reverse or change this process.

From this basis, we recommend that:

- Education for all nurses include mandatory subjects in Indigenous history, identity, culture, health and principles and self-determination and management;
- Indigenous studies are not to be included in multi-cultural studies. We are first nations people who have been and are still being colonised;
- Non-Indigenous university staff have colonisation and anti-racist workshops;
- Aboriginal and Torres Strait Islander Registered Nurses be utilised as consultants to faculties of nursing, to act as educators and mentors;

- The implementation of a process whereby Aboriginal and Torres Strait Islander nurses are able to learn about their history for personal growth and development;

- Aboriginal and Torres Strait Islander Registered Nurses will negotiate funding to attend international health forums, and to write a book of Indigenous nurses' stories;

- Aboriginal and Torres Strait Islander nurses and students of nursing have access to culturally appropriate counselling services with confidential referral.

Cultural safety underpins all nursing practice. We therefore endorse the Aotearoa (New Zealand) model of Cultural Safety and believe this should be implemented in Australia in ways that are empowering for us.

Recruitment and retention of Aboriginal and Torres Strait Islander nursing students

CATSIN will raise the issue of maintaining and increasing the number of Aboriginal and Torres Strait Islander students into the nursing profession by designating student places specifically for Indigenous people. This will require achieving commitment from:

- All faculties of nursing;

- The chief nursing officer/adviser in each State;

- Aboriginal and Torres Strait Islander and Educational organisations at local, State and national levels.

Universities must work together with CATSIN and other Aboriginal and Torres Strait Islander organisations to develop and implement strategies and policies on the recruitment and retention of Aboriginal and Torres Strait Islander students.

An Aboriginal and Torres Strait Islander person is to be employed in all nursing faculties to support students.

Bridging programs must be developed and made available to all prospective Indigenous nursing students.

Universities and OATSIHS are urged to examine the feasibility of distance learning in remote and rural hospitals and communities for Indigenous and non-Indigenous nursing students to gain practical experience as part of the curriculum.

Long term strategies need to be developed and implemented which will facilitate the articulation of nursing education for Aboriginal Health Workers in rural/remote programs into nursing.

Education

The Forum makes the following clear recommendations in relation to undergraduate, postgraduate and ongoing education for Indigenous and non-Indigenous nurses.

Each faculty or school of nursing will establish a curriculum advisory body in relation to the development and implementation of a compulsory component of Aboriginal and Torres Strait Islander health in the nursing curriculum, which reflects the diverse nature of Aboriginal and Torres Strait Islander society and the effects of colonisation on our health.

This body, whose membership is predominantly Aboriginal and Torres Strait Islander people:

- Will work in partnership with Aboriginal and Torres Strait Islander centers in universities (where they exist).
- Will be part of the university's strategic plan in Indigenous higher education. In particular the teaching of Indigenous matters by Indigenous people.
- Will ensure curriculum development and content relates to the Agreement on Aboriginal and Torres Strait Islander Health signed by Aboriginal and Torres Strait Islander Community Controlled Health Services, ATSIC, the Commonwealth Health Minister and the State and Territory Health Ministers.

In States or Territories where an agreement has not been signed, the curriculum advisory body consults with:

- Indigenous community controlled health services' peak organisation;
- The Indigenous health unit within the State or Territory department; and
- Local Indigenous health organisations.

There is endorsement and reflection of recommendations arising from:

- National Aboriginal and Torres Strait Islander Health Strategy, 1989
- Stolen Children Inquiry 'Bringing Them Home'
- The Royal Commission into Aboriginal Deaths in Custody.

There is compulsory placement for all nursing students in an Indigenous community or Indigenous community health organisation, appropriately arranged with each participating community.

Practical experience undertaken in undergraduate and graduate nursing education must be in a meaningful and realistic combination of community and hospital settings.

There is mentorship for Indigenous students.

There is targeting and filling of places in all levels of nursing by Indigenous people.

Creation of career structures recognising experience and knowledge in Indigenous health and community issues.

Acknowledgment will be given to prior learning.

Bridging courses shall be developed in line with the needs of Indigenous students and prospective students for entry into nursing course, rather than generic bridging courses.

Relationship between the roles of the Aboriginal Health Worker and the Aboriginal and Torres Strait Islander RN

The Forum acknowledged the vital role of AHWs as part of the primary health care team. Recommendations reflect the Forum's view of the importance of AHWs and the importance of an approach to health care delivery which integrates the roles of RNs and AHWs.

This Forum recognises that when the different roles of the RN and AHW are combined, a more cohesive approach to health care delivery will be achieved and makes the following recommendations:

- Aboriginal and Torres Strait Islander health, primary health care and community development must be compulsory in the nursing curricula and AHW education programs.

- Aboriginal and Torres Strait Islander community members must be involved in the design, development and teaching of nursing curricula and AHW education programs.

- Compulsory placement of student nurses in an Aboriginal and Torres Strait Islander community to better understand primary health care delivery and the role of the AHW.

- This forum supports the short term placement of the AHW in government health services, including hospitals, to give AHWs a better understanding of the role of the RN.

- Professional recognition be given by RNs of the unique role of AHW by supporting the professional development of AHWs.

- The local Aboriginal and Torres Strait Islander community defines the roles and responsibilities of the RN and the roles and responsibilities of the Aboriginal Health Worker working within and for that community. CATSIN will liaise with NACCHO at all times in relation to community health organisations.