

# Universities Australia's submission to the Commonwealth Department of Health & Aged Care's consultation paper: Developing the national nursing workforce strategy

December 2023

Thank you for the opportunity to respond to the Department of Health and Aged Care's (DOHAC's) development of the National Nursing Workforce Strategy. Nurses comprise the largest sector of the health professional workforce in Australia. They are highly skilled practitioners who play major roles in all parts of the health, aged care and disability system. There is currently a significant predicted shortfall of nurses in Australia – and globally – across all service settings and locations.

## The university role in health and medical workforce development

Universities Australia (UA) is the peak national body representing Australia's 39 comprehensive universities. Australian universities play a critical role in nursing and other health workforce formation. They educate and train virtually all of Australia's new-entry domestic health professional workforce<sup>1</sup>. Without universities, there would be a significant shortfall – greater than there already is – of these vital professionals.

This submission focuses on nurses educated and trained in universities<sup>2</sup>. This is predominantly, but not exclusively, Registered Nurses (RNs) with a Bachelor of Nursing (BoN) degree and Nurse Practitioners (NPs) with Master level qualifications.

- Thirty-three member universities (85 percent) currently deliver BoNs leading to initial registration as an RN.
- Thirteen member universities (33 percent) offer Master level qualifications leading to endorsement and registration as NPs; and
- eight member universities offer Diplomas of Nursing leading to Enrolled Nurses (EN) registration.

Many universities also provide a range of approved education courses to support domestic and international nurses upskill, reskill and/or re-enter the workforce. In addition, universities make significant contributions to nursing/health-related research and in supervising nurses to undertake Doctoral studies<sup>3</sup>.

A growing number of universities (eleven currently) also offer Master level entry-to-practice courses leading to registration as an RN. This reflects a growing trend for students already holding other qualifications to take up nursing as a second career.

UA's response is from a whole of university sector perspective. Key points and recommendations are provided below. Responses to selected consultation paper questions are also provided where relevant to nurse education/research across the sector. For responses specific to nursing education per se, please refer to the Council of Deans of Nursing and Midwifery's (CDNM's) submission.

---

<sup>1</sup> This includes domestic and international students studying for professional entry qualifications in Australian universities.

<sup>2</sup> The term "nurse" refers to variably qualified health professionals ranging from Assistants in Nursing (AINs) who generally have certificate iii qualifications to Nurse Practitioners who hold master level qualifications and/or PhD qualified nurse researchers /academics. Few universities offer AIN courses.

<sup>3</sup> Universities also offer midwifery degrees – either in conjunction with nursing or as direct entry qualifications.

## Key points and recommendations

- A. **Work with relevant stakeholders to grow quality, diverse placement capacity for nursing students – and/or acceptable alternatives - in health, aged care and disability services.**  
This is an urgent priority if we are to meet Australia's increased nurse education/training and workforce needs across the health, aged care and disability sector.
- B. **Build on/expand effective existing models regarding rural workforce, cultural safety and inclusion/diversity support.** Models such as the Rural Health Multidisciplinary Training (RHMT) Program; the National Rural Health Student Network; and UA's Indigenous Strategy already exist and are helping to address these areas. Building on these already effective approaches will bring further gains.
- C. **Implement recommendations in UA's submission to the National Aboriginal and Torres Strait Islander Workforce Strategy<sup>4</sup>** regarding supporting university-Aboriginal Community Controlled Health Service (ACCHS) partnerships to build culturally appropriate clinical education/placement capacity.
- D. **Consider expanding the John Flynn Placement Program (JFPP) to nursing** and other health discipline students – with a particular focus for nursing on small rural towns. Through the original JFPP, medical students developed relationships with rural communities over their degree life-time and were more likely to return to work in those communities post-registration. Offering similar opportunities to nursing/other health students is likely to bring similar gains.
- E. **Consider developing a “Health Housing” scheme**, similar to Defence Housing to ensure accommodation for health students and workforce across Australia, especially in rural areas.
- F. **Establish a student bursary for rurally-based nursing students** that need to undertake metropolitan placements to complete their study.
- G. **Expand PhD scholarships for nursing students:** Dedicate a proportion of the Medical Research Future Fund (MRFF) and/or National Health and Medical Research Council (NHMRC) funds to nursing-related and nurse-led research fields. This could include specific clinical research and/or relevant health services/workforce research.
- H. **Develop a well-articulated clinical academic pathway for nursing and publicly promote nurse academics and researchers where possible.** COVID offered many opportunities for nurse academics to use their clinical and research knowledge to convey important messages to the public. These examples could be built on in other relevant areas both to promote nurse researchers and nursing as a career more generally. Universities Australia would be pleased to discuss ways we could assist with this.

Further details about these and other points are provided in our responses below.

## General comment

The Australian Department of Health and Aged Care (DOHAC) predicts a shortage in Australia of 85,000 nurses by 2025 and 123,000 nurses by 2030<sup>5</sup>. Factors such as technology and skilled migration will play a role in maximising the existing workforce and boosting nursing numbers.

---

<sup>4</sup> [https://universitiesaustralia.edu.au/wp-content/uploads/2021/04/210408\\_sub\\_Submission-Aboriginal-and-Torres-Strait-Islander-Health-PlanPDF.pdf](https://universitiesaustralia.edu.au/wp-content/uploads/2021/04/210408_sub_Submission-Aboriginal-and-Torres-Strait-Islander-Health-PlanPDF.pdf)

<sup>5</sup> DOHAC as quoted on the [Australian Practice Nurse Association](#) website

However, technology will largely augment, not replace, nursing skills. As nurses are in short supply globally, the extent to which migration can fill workforce gaps is also limited.

To meet our signalled health, aged care and disability needs, it is clear that:

- significantly more nurses are required – at all levels of qualification; and
- the majority of these nurses will need to be educated and trained in Australia.

An important, although not sole<sup>6</sup>, component of achieving this goal is enabling more students to enrol in and complete domestic nursing studies.

University nursing degrees are popular courses. Not only are more people choosing to study nursing as a second career, significantly more students apply to study nursing than are subsequently offered places/enrolments. This is particularly true of, but not limited to, students applying to undertake BoN courses. The key limit on nursing student enrolments is availability of clinical placements. These are mandatory in all pre-registration - and many advanced - health professional courses. Yet placement capacity is largely dependent on health services. Lack of access to sufficient, quality, diverse clinical placements in health, aged care and disability services - and/or lack of evidence-based, safe, acceptable alternatives to placements - limits the number of additional nursing students that can be enrolled. A growing additional issue in regard to placements is placement poverty.

Our key recommendation is to work with relevant stakeholders to determine how to expand quality placement capacity and/or implement acceptable evidence-based alternatives. This is an urgent priority if we are to meet Australia's increased nurse education/training and workforce needs across the health, aged care and disability sectors. UA's ideas about how to address these matters have been covered in previous submissions to DOHAC (referenced as relevant elsewhere in this submission) and more recently in our submissions to the Commonwealth Department of Education's Universities Accord<sup>7</sup> (see Appendices 1 and 2 in this submission for relevant extracts/other information). We welcome the opportunity to work closely with Government, the professions, accreditors, regulators and service providers in this regard.

## Responses to selected consultation paper questions

### The growing need in aged care services

#### 1. What effect will the ageing population have on the nursing workforce needs of tomorrow?

Aged care workforce need is predicted to grow from 366,000 to 980,000 workers by 2050<sup>8</sup>. A significant component of this workforce will be nurses. In addition, the increased requirements for residential aged care facilities to meet legislated RN-to-client staff time ratios means that more RNs will be needed in care homes (see also Box 1 below). As Australia's population ages and an increasing number of older people choose to age at home, additional nurses will also be needed to provide in-home care. This is against a background of growing overall demand for nurses across sectors. The effects of this on the nursing workforce and education are as follows:

- more nurses at all levels<sup>9</sup> and therefore more nursing students and related clinical experience placements will be needed overall.
- nursing students and qualified nurses will need more exposure to aged care as a career option. This includes, but is not limited to:

---

<sup>6</sup> Other aspects such as the workplace environment, career pathways, Industrial Relations are also important but are out of scope for UA

<sup>7</sup> <https://universitiesaustralia.edu.au/wp-content/uploads/2023/09/UA-Response-to-Accord-Interim-Report.pdf>

<sup>8</sup> Source: Senate Community Affairs Committee - Future of Australia's aged care sector workforce 2017

<sup>9</sup> That is: Assistants in Nursing (AiNs), ENs, RNs, NPs.

- experiences during pre-registration nursing education and placement which focus on developing gerontological nurse competencies and not just fundamental nursing skills within an aged care setting; and
- promotional campaigns to show the rewards, and boost the appeal, of nurses working in aged care.

The 2023 Federal budget measure to support increased nursing student placements in primary and aged care settings is a useful first step towards this goal. However, more will be needed. This includes funding for career development and awards for aged care post-graduate qualifications that have parity with the public sector. However, these are not within the remit of higher education. In addition, it will be important to work with universities, service providers and other stakeholders not only in regard to building further placement capacity, but also about ensuring quality experiences and the best timing of exposure to aged care placement for nursing students.

**Box 1:** While the new focus on RNs in aged care is important, aged care offers scope for nurses to work across a range of qualification levels – from AiNs to NPs. Nurse-led models of care (both NPs and RNs) within palliative and aged care can significantly reduce client needs for general practice, time spent in tertiary hospitals and/or improve the quality of end-of-life care<sup>10 11</sup>. This is better for the client, the system and for nurses who see clearly demonstrated leadership and career trajectories. Yet, NPs are still uncommon in aged care.

A further unintended consequence of the recently mandated minimum RN to aged care client minutes is to reduce the number of ENs in aged care: many aged care providers are now not taking on as many - or sometimes any - EN students, nor employing as many ENs<sup>12</sup>. Nursing students at all levels need clinical experience as part of multiprofessional teams with a range of variously qualified nursing and other staff. This helps students better understand their own and others' practice scopes and further develops interprofessional communication. ENs offer a stepping stone along the nurse career pathway and NPs show where careers can lead. UA suggests that further work is undertaken with tertiary education providers, aged care providers, the profession and government to address this need.

## The regional rural and remote nursing workforce

### 2. How do we grow, support and sustain the regional, rural and remote nursing workforce?

Nurses and midwives are one of the more evenly distributed health workforces across different geographic regions. Similar ratios<sup>13</sup> of nurses and midwives are found across all geographic locations in Australia except for small rural towns (which show almost half the number of nurses per capita than in other regions). However, more nurses are still needed in rural areas given the well-known inequities in health status for people living in rural/remote Australia<sup>14</sup>.

The Rural Health Multidisciplinary Training (RHMT) Program supports university students from a range of health disciplines, including nursing, to undertake extended periods of training in rural

<sup>10</sup> Reducing time in acute hospitals: A stepped-wedge RCT of a specialist palliative care intervention in residential care homes, 2020: <https://pubmed.ncbi.nlm.nih.gov/31894731/>

<sup>11</sup> Improved quality of death and dying in care homes: A palliative care stepped-wedge RCT in Australia 2019: <https://pubmed.ncbi.nlm.nih.gov/31681981/>

<sup>12</sup> ENs do not count towards the RN ratios and are more expensive to employ.

<sup>13</sup> Approximately 1200 Full Time Equivalent (FTE) nurses/midwives per 100,000 head of population. Source: Commonwealth Department of Health and Aged Care Workforce fact sheets: <https://hwd.health.gov.au/resources/publications/factsheet-nmw-2019.pdf>

<sup>14</sup> Due to both higher overall disease burden and reduced health service access compared to metropolitan communities.

locations. This DOHAC funded program, which includes University Departments of Rural Health, Rural Clinical Schools and Regional Training Hubs across Australia, develops and supports rural placements. The RHMT program has been shown to produce beneficial rural health workforce and research outcomes<sup>15</sup>.

The Rural Health Student Network (RHSN) is another well-established, DOHAC funded program supporting rural health careers across all disciplines, including nursing. It provides a voice and offers peer support for students interested in practising rural health and improving rural health outcomes.

Despite these two successful initiatives, two issues still limit rural clinical experiences – and/or subsequent employment for nursing students:

- I. limited access to secure accommodation in rural areas or nursing students and sometimes academic staff; and
- II. support for rurally based students who need to travel to metropolitan areas to undertake placements.

Re point i: The RHMT Program already offers some accommodation support. However, significantly more is needed. While extending RHMT program funding to cover more accommodation is one option, an alternative approach would be to develop a “Health Housing” scheme along the lines of the well-established Defence Housing scheme. Defence Housing is a public-private venture that enables housing to be provided for Defence personnel and their families across Australia. It offers a guaranteed rental return, long-term leasing and a range of property services. A similar scheme for health could support accommodation needs for students, staff and health workforce in rural Australia.

Re point ii: There is currently no systematic support for rurally based students to undertake mandatory placements in metropolitan areas, even though these students intend to remain in their local rural area to practice nursing post-graduation. Financial and other challenges in coordinating the relevant accommodation can delay students’ course progression or, if severe, can lead to course withdrawal. Support for students to access necessary metropolitan-based placements would assist.

**We recommend:**

- **continuation and expansion of the RHMT and RHSN programs to further support the rural nursing workforce;**
- **consideration of development of a “Health Housing” scheme to secure accommodation for students and health workforce in rural and, where needed, other areas across Australia; and**
- **access to student bursaries to support rurally based nursing students access necessary metropolitan based placements.**

We also suggest development of a similar program to the original John Flynn Placement Program (JFPP) for nurses and other health students<sup>16</sup>. The original JFPP supported medical students to build ongoing relationships with rural communities to increase the likelihood of them returning to

---

<sup>15</sup> KBC Evaluation of the RHMT program 2019

<sup>16</sup> The John Flynn Placement Program originally supported medical students to build relationships with rural communities over continuing years of their medical school education with the goal of increasing their likelihood of returning post registration. The program has recently changed to focus on junior doctor, rather than medical student placements.

practice in those communities post-registration. A similar type of JFPP for nurses could specifically focus on small rural towns where the nursing workforce is lowest.

**3. How will nurses in regional, rural and remote areas provide care in the future?**

This is out of scope for UA. We refer DOHAC to CDNMM's response for further detail.

## Cultural Safety

**4. How can we ensure the healthcare environment is culturally sensitive for nurses from diverse backgrounds?**

Culturally safe and sensitive environments are a key part of supporting nursing students from all backgrounds to complete their studies, enter the nursing workforce and to stay working once qualified. The nature of nursing education at university means that a significant portion of training occurs outside of the university environment. Universities receive anecdotal reports from some students that, at times, these experiences have been culturally unsafe. Universities have little influence over these off-campus health service environments. However, universities are undertaking the following actions to support safe, culturally sensitive environments for students/staff, including in nursing:

- The UA Indigenous Strategy. The strategy was updated in early 2022. It provides a clear vision and actions to reduce and eliminate racism on-campus and incorporate culturally-relevant pedagogy within universities.
- UA's Good practice sector guide for student safety and wellbeing. The guide outlines practical ways to support students across multiple areas and is aligned with UA's commitment to inclusion and diversity.
- UA's Sexual Harm response guidelines for the sector<sup>17</sup>.

In addition to the above, individual universities provide a range of institute specific services to support student diversity and wellbeing. Through DOHAC funding, university health professional students are also eligible to access various components of the nationally recognised Mental Health First Aid Training.

## First Nations nurses

**5. What actions should be taken to build and support the First Nations nursing workforce?**

The number of First Nations students enrolled in BoNs more than doubled between 2005 and 2018 (from 1.4 per cent in 2005 to 2.9 per cent in 2018). While this is encouraging, the proportion of First Nations students enrolled in nursing degrees is still below population parity (3.8 per cent at June 2021)<sup>18</sup>. First Nations students in also tend to have lower completion rates than non-Indigenous students. Universities continue to work to make campuses culturally safe including through a range of enabling courses and implementation of the UA Indigenous Strategy which has been endorsed by all member universities.

Ideas to support First Nations health workforce more broadly were also made in UA's submission to the National Aboriginal and Torres Strait Islander Workforce Strategy. The submission recommended time-limited funding to support partnership approaches between universities and Aboriginal Community Controlled Health Services (ACCHSs) – to develop culturally safe and pedagogically appropriate experiences for nursing students. We recommend policy support for implementation of the partnership approaches outlined in that submission.

<sup>17</sup> <https://universitiesaustralia.edu.au/wp-content/uploads/2023/07/UA-2023-008-Sexual-Harm-Response-Guidelines-web-v4.pdf>

<sup>18</sup> Australian Institute of Health and Welfare: <https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians>

CDNM also issued a National Apology at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) Conference in 2022<sup>19</sup>. The apology aimed to open a way forward for CDNM to build a better future for nursing and midwifery in partnership with CATSINaM. See CDNM's submission for further details.

Building on the existing programs and approaches outlined in responses to question 2 to 5 above will support further gains in these areas. Developing First nations nurses as leaders in the profession to provide culturally appropriate care and provide role models for the younger generation is needed, including in academia.

We suggest that relevant stakeholders are brought together to discuss how best to address leadership development, retention and racism. Properly resourced, CATSINaM is best placed to lead this work and we welcome the opportunity to work with CATSINaM, health services and other stakeholders to progress these matters.

## Career pathways and specialisation

### 6. How can nursing career pathways be articulated so that the workforce understands how to navigate and build a satisfying and stimulating career in nursing?

Nurses will need more flexible study and career pathways. Part of the reason for this lies in the demographics of nurses/nursing students as well as impending potential education policy changes. Approximately 35 per cent of university nursing students commence their studies at 26 years old or above (an age at which many already have family and work commitments). Twenty per cent study part time<sup>20</sup>. Most students are female. In addition, nursing degrees tend to comprise larger proportions of equity group students relative to other health disciplines. For example, in 2018, for nursing students:

- 24.3 per cent were from low SES groups;
- 7.2 per cent were from non-English speaking backgrounds;
- 5.3 per cent were from disability groups; and
- 2.9 per cent were Indigenous.

These percentages have all increased since 2011<sup>21</sup>.

Australia is currently undertaking a major review of higher education – the Universities Accord. A key goal of the Accord is to increase higher education attainment. Growth in enrolments is needed for Australia to meet a number of its skills and workforce needs. The Accord has signalled attaining this growth through widening participation. That is, to further increase and broaden university student participation from equity and diversity groups.

To attain growth through wider participation in nursing, more flexible study options will be needed. As outlined, nursing students already comprise high proportions of equity-group students. This proportion is liable to increase as participation widens. Widening participation in nursing courses will also have an impact on the growing issue of placement poverty. Given these factors, it is probable that nursing students will increasingly need to juggle study and work/family commitments, especially as costs of living rise. Providing flexible study avenues is primarily an education matter. However, other stakeholders such as regulators, the professions and health service providers, will also need to understand the need for - and be willing to work with universities to enable – more flexible education programs and clinical placements.

---

<sup>19</sup> <https://www.cdnm.edu.au/cdnm-national-apology-at-catsinam-conference>

<sup>20</sup> These figures have remained stable over the last decade.

<sup>21</sup> Commonwealth Department of Education, unpublished Higher Education Information Management system (HEIMS) dataset

Nurses will also need more flexible career pathways. Where necessary, these will need to be supported through well-defined and supported study pathways including:

- within VET to support AIN to EN transition;
- between VET and higher education to support EN to RN development – and vice-versa; and
- within higher education – to support RN to NP development<sup>22</sup>.

To support more flexible career pathways, nurses also need to be able to move more easily across health, aged care and disability services as well as between primary, secondary and tertiary care. Currently, movement across sectors is not easy for a variety of IR/HR reasons.

Flexibility also needs to encompass:

- earn-while you learn approaches where students can work in nursing roles while learning – e.g. the Registered Undergraduate Student of Nursing (RUSON) model; and
- portfolio careers that allow nurses to move not only between different service settings but also across sectors – such as more opportunities to work across health and academia/education; and
- career development pathways that provide postgraduate specialist development., similar to that in the medical education mode<sup>23</sup>.

Such flexibility would go some way to supporting more nurse involvement in research and higher degrees – see also response to question eight.

Much of this is articulated in UA's response to the Universities Accord Interim Report and in UA's related statement on the Ideal Health Professions Education State (see Appendices 1 and 2). We would be pleased to discuss our ideas further with the Department as relevant.

## Nurses' health and wellbeing

### 7. What are the barriers and enablers that need to be overcome to enhance workplace cultures for nurses?

This question is largely out of scope for UA. However, part of the issue is that, despite some positive change over recent years, there are still problems in where and how nurses are perceived within the health system hierarchy<sup>24</sup>. From an education perspective, it is worth noting that interprofessional education (IPE) may support enhanced views of nurses by building greater understanding and respect for each profession's different strengths. IPE is a requirement in the accreditation standards of all approved university health courses. While IPE can help to an extent, this understanding and respect must also be modelled/reinforced in health services.

## Building nursing research capability

### 8. What actions/change needs to occur to build capacity and numbers of nurse researchers across whole of health?

A greater focus on clinical academic career pathways in nursing is needed. This could start with supported Honours programs and move through to doctoral/postdoctoral studies and clinical chairs. A similar model already exists for medicine in Australia and internationally for nursing in

---

<sup>22</sup> This pathway is already amongst one of the most well-defined between VET and HE.

<sup>23</sup> To date the only pathway is the Nurse Practitioner pathway with the Australian College of Mental Health Nursing. It provides credentialling for Post-Graduate (PG) Mental Health courses. PG credentialling could extend to children's nursing, child & family, sexual health, oncology, aged care etc.

<sup>24</sup> [Perception of the image of the nursing profession and its relationship with quality of care](#) BMC Nursing 2022



countries such as the UK<sup>25</sup>. CDNM/higher education providers could work with health services representatives and the professions to further articulate potential pathways.

PhD enrolments specifically in nursing increased 21 per cent from 2011 to 2021. From 2011 to 2019, enrolment growth in nursing PhDs was 67 per cent<sup>26</sup>. However, PhD enrolment figures for nursing declined by 28 per cent between 2019 and 2021, most likely as a result of COVID when there was a national call for nurses to return to clinical roles. This PhD enrolment growth is significantly higher than in a number of other subject areas. Despite this, actual numbers for enrolments in nursing PhDs are still low. For example, at their height in 2019, only 412 students were enrolled in nursing PhDs, compared to 951 enrolments in Architecture and Building PhDs and 13,473 enrolments in Natural and Physical Sciences.

Barriers to nurses enrolling in PhDs are likely to relate to nursing comprising higher numbers of “first in family”<sup>27</sup> and equity group students than many other courses. While PhDs remain poorly paid and are seen as highly academic (rather than clinically relevant), they may be unattractive to nurses.

The issue of PhD student poverty is well established. It has been raised in multiple submissions and in the media<sup>28</sup>. UA continues to call for an immediate increase in the base stipend for PhD students (while maintaining the current numbers funded). This would have a profound impact on improving living standards of all PhD students. It would especially have an impact in reducing barriers for underrepresented cohorts seeking to undertake a PhD. Establishing conditions and remuneration for PhD students that allow them to undertake a Higher Degree by Research while receiving a reasonable living wage is one way to reduce barriers to nurses participating in research.

In addition to increasing PhD stipends, UA also recommends championing nurses in academia and finding ways to publicly promote nursing academic/research achievements. COVID offered opportunities for nurse researchers to reassure and inform the community. They were heard nationally/internationally in ways that combined their clinical communication skills with relevant research. Developing opportunities for nurse researchers to comment more regularly on broader public health matters could help raise the profile of nurse academics and illustrate how to combine these two important skills. UA would be pleased to work with DOHAC on how to support such promotion.

Nurse-led research also tends to attract less government funding than non-nurse led research<sup>29</sup>. To develop greater nurse research capability, UA recommends greater investment in nursing and nurse-led research and the development of clinical academic pathways.

## Recruitment and retention

### 9. How can we increase the recruitment and retention of nurses to meet the current and future demand?

---

<sup>25</sup> Transforming healthcare through clinical academic roles in nursing midwifery and allied health <https://www.medschools.ac.uk/media/2325/aukah-transforming-healthcare.pdf>

<sup>26</sup> Dept. of Education, unpublished HEIMS dataset. Estimates derived by filtering all doctorate courses with the word “nursing” or a cognate field (e.g. “midwifery”). Courses without such words were excluded from analysis. Many nurses could also be undertaking PhDs in more generalised health fields.

<sup>27</sup> That is, students may be the first ever in their family to attend university.

<sup>28</sup> e.g. <https://universitiesaustralia.edu.au/submission/uas-response-to-the-diversity-in-stem-review-draft-recommendations/>

<sup>29</sup> A scoping review of nurse-led randomised controlled trials 2023: <https://onlinelibrary.wiley.com/doi/full/10.1111/jocn.16632>

Recruitment and retention in the workplace is out of scope for UA. For recruitment into nursing courses, see point A in key points and recommendations above. See CDNMs submission for comment on university retention.

## **The future of nursing in Australia**

**10. What should our ambition and vision for the nursing workforce be in the future?**

**11. What will the nursing workforce of the future look like?**

**12. How does the system need to change to support a sustainable, future fit nursing workforce?**

See attachment A – UA's Health Professions and Clinical Education: Ideal State - submitted to the Universities Accord interim Report. The statement sets out our ambition and vision for health professions workforce and related education and training for all professions, including nursing.

## **A workplace that thrives on a positive culture empowered by accomplished leaders, fully supportive of their nurse workforce**

**13. What are the barriers that need to be overcome to enhance workplace culture and conditions for nurses?**

This is out of scope for UA.

## **Delivering person-centred care**

**14. How do we equip nurses to deliver person-centred care?**

This is best answered by CDNMs.

**15. What changes are required to deliver person-centred care of the future?**

As above

## **Nurses working to their optimum scope of practice**

**16. Assuming a wider scope of practice for nurses in the future, what are the emerging roles nurses will need to fill?**

See CDNMs submission to this consultation and UA's recent submission to the scope of practice review<sup>30</sup>.

**17. What are the most important skills and capabilities required of nurses in the future?**

This is largely out of scope for UA. However, models of care will continue to change including through increased use of technology, greater interprofessional collaborative practice (IPCP) and potential expanded scopes of practice. To best educate future nurses with the right skills and knowledge, it will be critical that digital capabilities, IPCP and expanded scopes are embedded in nursing education through partnership approaches with the professions and health services.

## **Technology drives a very different workforce and health service**

**18. What are the main ways technology will change the role of a nurse in the future?**

This question is largely out of scope for UA. However, as stated above, it will be important for universities and other education providers to incorporate ongoing changes in technology into curricula in a timely way to best prepare future nurses for the workforce.

---

<sup>30</sup> [https://universitiesaustralia.edu.au/wp-content/uploads/2023/11/Submission\\_scope-of-practice-review-survey-response.pdf](https://universitiesaustralia.edu.au/wp-content/uploads/2023/11/Submission_scope-of-practice-review-survey-response.pdf)

## Education and lifelong learning that provides high quality skills

### 19. What educational opportunities/career pathways changes will support future workforce?

Much of this has already been answered in other parts of this response. (For example, see point A in *Key points and recommendations*. See also responses to Qs 6 and 8 above.) Two further points are worth noting:

- I. Internationally, Australian nursing education programs are regarded as some of the best in the world. We continue to rely on sufficient, quality and diverse placements to deliver and expand this education. Strong partnership approaches are key to this. We welcome all opportunities to work with health service providers and other relevant stakeholders to determine sustainable, quality placement approaches.
- II. Currently, many RNs undertake a three-year BoN as the basis for a forty year plus career. Continuing professional development is a mandatory requirement to retain registration and support currency of practice. However, enabling further education opportunities and qualifications attainment for nurses is strongly encouraged. This is important both:
  - a. as care changes/becomes more technologically driven; and
  - b. to support career development and professional status – both areas already flagged for improvement.

## Career pathways that are globally aligned, nationally recognised and provide structured progress

### 20. How can we improve nurse career progression to ensure lifetime nurse retention?

In relation to study and qualification pathways for career progression: many of the pathways from EN to RN to NP already exist and are generally well established. However, salary increases relevant to qualification attainment are less consistent, particularly in relation to the transition from RN to NP. While this is largely out of scope for UA, it is likely that more appropriate salary changed mapped to qualifications and experience may help with nurse retention. Aspects of our responses to questions 6 and 8 also touch on retention.

## Appendix 1: Health Professions and Clinical Education - Ideal State

*From UA's submission to the Universities Accord September 2023*

The ideal future state of Health Professions Education (HPE) in Australia is one in which:

1. Education and training the future **health workforce**:
  - is recognised as **critical to national wellbeing**;
  - **supports the provision of quality care** to address diverse and dynamic community needs; and
  - delivers **workforce self-sufficiency** through Australian-based education - with only minimal, short-term need to recruit overseas-qualified staff.
2. These objectives are achieved through **long-term collaborative planning and deep partnerships** between governments, the professions, health services and tertiary education providers. Alliances recognise partners' shared responsibility to meet Australia's future health workforce needs.
3. All stakeholders receive **high quality and timely data** from a common, trusted and authoritative source **about changing health workforce and skills needs** to inform their decision-making about funding, enrolments, course delivery and the provision of placements.
4. Domestic and international students in all disciplines can readily access affordable and sufficient **clinical placements that provide high quality learning and diverse experiences** - see Box 1.
5. Tertiary education providers operate under **streamlined health professional accreditation processes** across disciplines and between education and professional accreditation.
 

Processes:

  - focus on outcomes, are evidence-informed, allow for innovation and remove artificial distinctions between NRAS and non-NRAS disciplines; and
  - do not duplicate accreditation/registration processes and requirements through TEQSA or ASQA.
6. Tertiary education providers have access to funding to **evaluate** the impacts of educational innovations in health professional education.

### **Box 1. Ideal placements** are ones where:

- placement settings and locations support students' flexible learning needs and their contribution to patient care while reflecting accreditation and health service requirements;
- placement volume and capacity match tertiary education provider need and changing workforce demand;
- placements can be accessed nationally and efficiently;
- placement funding models are consistent, transparent and equitable across disciplines, services and jurisdictions and support interprofessional learning;
- placement resources (such as tools to assess placement capacity and quality placement models) are accessible nationally by tertiary education providers;
- students can access financial resources, where needed, to meet living costs while on mandatory placements; and
- virtual placement and simulation approaches can replace, or be augmented with, actual placements, where evidence shows this to be equal to or better than the latter.

## How might we get there?

### Health workforce planning and development

- Establish an enduring, national, cross-portfolio, multi-jurisdictional mechanism to undertake comprehensive health workforce planning across the health, aged care and disability sectors<sup>31</sup>. Planning will:
  - be underpinned by robust, national workforce supply/demand data interrogable at state, regional and local levels to enable timely mapping of workforce stress points;
  - include data on clinical placement capacity, availability, diversity and quality; and
  - incorporate scenario planning and ongoing examination of the impacts of new technology on workforce and skills needs.
- Ensure inclusion of the tertiary education sector voice from the outset in all health workforce policy formation and planning.
- Build on universities' regional infrastructure<sup>32</sup> to act as anchor sites for workforce development.
- Establish agreements between Health and Education departments and tertiary education providers that provide funded support for:
  - regionally customised health workforce outcomes;
  - tertiary education providers to offer accredited programs that enable professionals to work to their full scope and/or in new or advanced practice roles across the disciplines; and
  - education models that can skill/reskill/upskill new and existing workforce quickly, while ensuring quality outcomes. Models could include:
    - micro-credentials and fast-tracking students based on recognised RPL and competency framework assessments as well as traditional post-graduate training;
    - combining ongoing health service work with further study ("earn as you learn" apprenticeship-type models or paid student assistant roles);
    - an easy-to-navigate tertiary system with clear pathways within and between sectors to support career progression and upskilling/reskilling for advanced practice roles; and/or
    - promoting student diversity and participation to better reflect and respond to service need.

### Placements

- Task National Cabinet Health Ministers with the development and oversight of a national health workforce framework. The framework will:
  - align health workforce planning with the provision of funding and placements to tertiary education providers for students in health professional courses in each jurisdiction; and
  - establish consistent and transparent processes for the above in each State and Territory.
- Establish transparent and accountable partnership agreements between health/aged care/disability services and tertiary education providers regarding placements. Agreements:
  - recognise the reciprocal contributions of health services, practitioners, universities and other tertiary education providers to current and future health care and workforce development;
  - acknowledge and draw equitably on the funds that flow to education and health service providers for teaching, training and research; and
  - commit to increasing quality interprofessional education during placements.

<sup>31</sup> These sectors draw on the same health/care workforce, but policy and funding is across different portfolios and government tiers.

<sup>32</sup> Such as regional training hubs, University Departments of Rural Health, Rural Clinical Schools and regional campuses.

- Establish a pooled workforce development fund<sup>33</sup> specifically to develop new/expand existing placement capacity and quality in health services. Funds could be drawn on for:
  - supervisor training and credentialling;
  - grants for partnership approaches between universities and health, ageing and disability services to develop quality, sustainable placement models to address identified local workforce/skills needs including in rural and remote Australia;
  - supervisor and student accommodation especially in regional/rural locations; and
  - student bursaries where students lack the financial capacity to complete mandatory placements.
- Invest in primary, aged and disability care and the Aboriginal Community Controlled Health sector as quality teaching, training and research systems.
- Expand and uplift supervision capacity by:
  - increasing the inclusion of supervision activities in health practitioner position descriptions;
  - having supervision included in practice standards set by Health Boards under AHPRA; and
  - increasing use and acceptance of interprofessional supervisory models.
- Ensure the next National Health Reform Agreement Addendum includes shared Commonwealth and State responsibilities for:
  - reporting on the delivery and performance of teaching, training and research in the tertiary and community health sectors; and
  - upholding health workplaces to be safe and supportive learning environments that enable flexible career progression and pathways.

## Accreditation

- Build on the growing focus on learning outcomes rather than processes.
- Remove the artificial distinction between NRAS and non-NRAS professions by:
  - bringing all health disciplines under the oversight of AHPRA for registration, accreditation and workforce data collection purposes; and
  - regularly bringing tertiary education providers, health professional and accrediting bodies together to share and participate in accreditation development and progress.
- Consolidate accreditation processes between TEQSA, ASQA and the health professions to reduce duplication and enable joint assessments of shared academic and health professional areas.
- Provide options for universities to synchronise health professional accreditation into a common agreed cycle for all disciplines, where this is preferred<sup>34</sup>.
- Ringfence a proportion of NHMRC or MRFF funding for dedicated health services research including Health Professions Education models that can be shared with accrediting bodies and the professions.
- Bring accreditation bodies and the university sector together on a two to three-yearly basis to discuss relevant findings from the above and their incorporation into education/accreditation.

<sup>33</sup> Potentially administered through Jobs and Skills Australia (JSA) with funds from Education, Health/Aged Care and Social Services.

<sup>34</sup> This approach supports reduced duplication across disciplines and facilitates interdisciplinary learning/teaching.

## Appendix 2: Placement Poverty

*From UA's submission to the Universities Accord September 2023*

In many areas of national workforce need (e.g., health, education) degree courses include compulsory placements. UA welcomes the [Universities Accord Interim] report's focus on placement poverty and suggestions of student stipends for compulsory placements. These stipends should reflect a cost-of-living allowance rather than payment for a work-based placement. The latter risks redirecting the focus away from a quality educational experience to payment for work.

Furthermore, widening participation and workforce growth will not be possible unless more industry placements are unlocked and governments work with industry, the professions and education providers to provide fair and accessible access to these placements. In many cases, the cost of placements imposed by states and territories has become untenable. We recommend a multi-stakeholder committee be established to determine how best to unlock more – and more diverse – quality placements and how to design and administer stipends to support students as they undertake them.

### **Placement poverty - additional information**

Placement poverty refers to the unmanageable cost-of-living pressures students may face on compulsory professional experience/work placement. It is more likely when students:

- are already struggling financially;
- have very high compulsory placement hours;
- undertake placements away from their usual abode, especially where this requires paying for both temporary accommodation and their normal rent; and/or
- must forego their usual/other work income to meet their placement obligations.

UA recommends a multi-stakeholder professional placement committee be formed (see below). The committee's remit would be to determine how best to support quality learning in supervised professional experience placements. This would include identifying methods to address placement poverty (if found to be significant) and placement issues more generally - through:

- agreeing greater flexibility in placement requirements (e.g. total hours; RPL of previous/current work experience; greater use of simulated placement);
- increasing access to subsidised placement accommodation for students (and supervisors) where needed, especially in rural/remote areas;
- developing guidance re a possible cost of living stipend for students experiencing placement poverty (how much, student eligibility, who administers it etc).

### **Professional Placement Committee: Proposed Membership**

Suggested representatives on the multi-stakeholder professional placement committee include nominees from the following sectors/agencies:

- Higher Education - including from disciplines requiring compulsory placement.
- Vocational Education and Training (VET)
- Students
- Relevant Industry and professional group representatives (e.g. Health, Education),
- Government including DSS, Education, Health, JSA.
- Regulators and accrediting bodies such as TEQSA, AHPRA, Health Professions Accreditation Collaborative Forum (HPACF).

For nursing, this could be done through the existing Nursing and Midwifery Education Advisory Network (NMEAN) potentially with additional representatives as needed (for example from the aged care and disability sectors, from JSA and/or from HumanAbility).