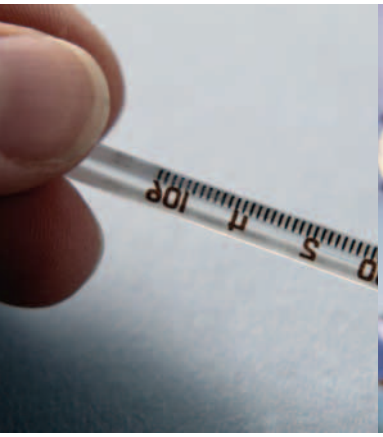
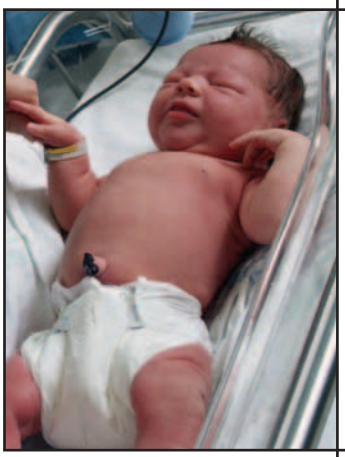
Commonwealth funding for clinical practicum




A report on Commonwealth funding to support the costs of clinical practicum for undergraduate nurses and midwives in Australia



The National Nursing and Nursing Education Taskforce (N³ET)
May 2006

Report on Recommendation 24
National Review of Nursing Education (2002) – Our Duty of Care

Australian Health Ministers' Advisory Council

This document may also be downloaded from the N³ET website at: **http://www.nnnet.gov.au/**

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List of Acronyms

ANMC	Australian Nursing and Midwifery Council
AUTC	Australian Universities Teaching Commission
AVCC	Australian Vice Chancellors Committee
CCC	Commonwealth course contribution
CGS	Commonwealth Grant Scheme
COAG	Council of Australian Governments
DEST	Department of Education Science and Training (Commonwealth)
HECS	Higher Education Contribution Scheme
HEP	Higher education provider
HES	Higher education sector
HSP	Health service provider
HSS	Health service sector
N³ET	National Nursing and Nursing Education Taskforce
RA	Regulatory authority (nursing and midwifery)
VC	Vice Chancellor
VET	Vocational education and training
WEI	Work experience in industry

The National Nursing and Nursing Education Taskforce (N^3ET)

In November 2003, State/Territory and Australian Government Ministers for Education and Health announced the establishment of the National Nursing and Nursing Education Taskforce (N^3ET/the Taskforce).

The Taskforce was established to implement and monitor 22 of the 36 recommendations of the National Review of Nursing Education 2002: *Our Duty of Care Report* (2002), along with work from three recent Australian Health Workforce Advisory Committee (AHWAC) nursing workforce reports: *The Critical Care Workforce in Australia 2001–2011* (2002), *The Midwifery Workforce in Australia 2002–2012* (2002), and *Australian Mental Health Nurse Supply, Recruitment and Retention* (2003), in addition to further work regarding nurse specialisation (see **www.nnnet.gov.au**).

The Taskforce brings together some of Australia's leading nursing and nursing education and training specialists who have been nominated for their leadership qualities and collective expertise. Members of the Taskforce are supported by a Secretariat located within, and supported by, the Department of Human Services, Victoria.

The Taskforce is "committed to an enhanced and sustainable healthcare system through the promotion of professional visibility and pride, quality education, regulation to nationally consistent standards, and capacity building in practice, education and research for nurses and midwives across Australia" (National Nursing and Nursing Education Taskforce 2003).

The Taskforce has the following terms of reference:

- To consider and develop proposals for implementation of the recommendations of the National Review of Nursing Education referred to the Taskforce by AHMC;
- To report to the Australian Health Ministers' Conference (AHMC), the Ministerial Council for Education Employment Training and Youth Affairs (MCEETYA) and the Australian National Training Authority Ministerial Council (ANTA MINCO) on implementation of the National Review of Nursing Education recommendations referred to the Taskforce;
- To consider and provide recommendations on any other nursing workforce or nursing education and training issues referred by AHMC such as AHWAC reports;
- To progress and report on implementation of recommendations on any other nursing workforce and nursing education and training issues approved by AHMC that are consistent with the Taskforce's priorities;
- To progress implementation of the above recommendations, including the development and execution of individual projects, under a work plan approved by Australian Health Ministers' Advisory Council (AHMAC);
- To operate for two years with continuation being subject to review by Health and Education and Training Ministers.

N³ET Membership

Chair	Adjunct Professor Belinda Moyes
Nominee of the Australian Minister for Health and Ageing	
Ms Rosemary Bryant	Executive Director, Royal College of Nursing, Australia
Nominee of the Australian Minister for Education & Training	
Professor Jill White	Dean, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney
Nominee of the Ministerial Council for Education, Employment, Training and Youth Affairs	
Professor Pauline Nugent	Head, School of Nursing, Deakin University, Victoria
Nominees of State & Territory Health Ministers	
Professor Mary Chiarella	Chief Nursing Officer, Department of Health, NSW (Nov 2003–Jul 2004)
Adjunct Professor Kathy Baker	Chief Nursing Officer, Department of Health, NSW (since Aug 2004)
Ms Fiona Stoker	Principal Nursing Advisor, Department of Health & Human Services, TAS
Nominees of the Australian National Training Authority Ministerial Council	
Ms Katherine Henderson	Deputy Chief Executive Officer, Department of Employment, Education & Training, NT (Nov 2003-Feb 2004)
Ms Di Lawson	Chief Executive Officer, Community Services and Health Industry Skills Council
Nominee – Private Sector	
Ms Sue Macri	Executive Director, Aged Care Association Australia (NSW)

Executive Summary

The National Review of Nursing Education (2002) *Our Duty of Care Report* recognised the vital importance of clinical practicum in nursing and midwifery preparatory education, but also noted the substantial costs associated with providing clinical practicum that meets the standards set by nursing and midwifery regulatory authorities (RAs). Recommendation 24 Funding for Clinical Practicum recommended that additional funds be devoted to supporting this component of undergraduate education.

As a result of the Higher Education Review, an additional $54 million (over 5 years beginning from 2004) has been allocated to undergraduate nursing programs and specifically to "be directed towards the costs associated with clinical practicum in nursing…"(Department of Education Science and Training 2004).

The role of the Taskforce in this recommendation has been to monitor the response and outcomes for clinical practicum in nursing and midwifery education, with regard to the policy impact.

The purpose of this paper is to report on spending by Australian universities of additional funding for clinical practicum for undergraduate nurses (and midwives) in line with the Commonwealth Our Universities: Backing Australia's Future policy. As directed, in preparing this report, consideration has been given to funding and other mechanisms to achieve the required clinical practicum outcomes in a range of health, community and aged care settings.

To evaluate the impact of additional Commonwealth funds to support nursing clinical practicum, the Taskforce requested information from universities offering undergraduate nursing programs to ascertain how funds had been utilised over time.

Thirty-four universities providing undergraduate programs for nurses responded. It is evident from the variable nature of responses that a comprehensive and complete data set is not achievable with respect to this matter. Reported data does, however, provide a "snapshot" or indication of how funding has been used by universities to support clinical practicum and commentary highlights a number of key issues for further consideration.

The Department of Education, Science and Training (Commonwealth) (DEST), indicates that in 2004, additional clinical practicum funding to universities was at a rate of $607 per equivalent full-time student load (EFTSU) based on 2003 student load figures, and was provided as a lump sum mid year. From 2005, DEST advises that additional funds are merged into the cluster funding or Commonwealth course contribution. In 2005, with standard indexation applied, the clinical practicum amount was $659 and in 2006 the amount is $688. The Government has recently committed additional funds to increase this amount to $1000 per full-time student for existing and new student places.

Responses to the survey regarding utilisation of additional clinical practicum funding highlight that higher education providers (HEPs) have welcomed additional Commonwealth funding to support clinical practicum, but have viewed this increment as going only part way towards meeting the actual costs of providing nursing programs that meet the regulatory standards required for licensing and the expectation of employers and health service providers (HSPs).

A number of pressures have been identified as contributing to the spiralling costs of clinical practicum, including minimum regulatory requirements for clinical practicum, administrative costs associated with increased numbers of students and clinical hours and charges by health services, supervision or partnership arrangements including liaison, consultation and supervision arrangements. It is evident that

while many of the program improvements implemented by universities are to align programs with the best practice benchmarks for clinical practicum identified in the AUTC report, they also contribute to substantial cost increases.

The view from universities is that DEST funding arrangements for nursing have been based on historical understandings of the components of nursing programs and are not keeping pace with the realities of educating nurses and midwives for licensing and contemporary practice. It is evident that the costs associated with nursing programs, and particularly clinical practicum, are now escalating to the point where the sustainability of nursing programs is a serious concern for higher education providers. Hence, there is a strong argument for DEST to review the baseline funding arrangements and policy to ensure HEPs can continue to provide quality programs that ensure graduates meet the requirements of contemporary practice in a complex and changing health environment.

Educational programs preparing nurses for licensing need to be responsive to the changing needs of the health service sector (HSS). At the same time, there needs to be a balance between Government, health service provider/employer and professional/regulatory interests. This clearly requires a cohesive approach that involves DEST funding policy, regulatory consistency, State/Territory Government contributions and moderation of the employer expectations, and a strategic vehicle to engage the stakeholders, manage competing interests and evaluate the impact and outcomes of new approaches to clinical practicum.

Such an approach should give consideration to further research into the impact and outcomes on competence and the cost of new and different approaches to clinical competence to bring greater clarity to decisions pertaining to minimum requirements. It should also consider a flexible and nationally-consistent regulatory framework that promotes innovative approaches to clinical learning and competence attainment and that is pedagogically sound, provides for safe practice, and is cost effective.

Exploring the tensions between what is needed to achieve competency requirements for licensing and what is required for work readiness, requires understanding of the capacity of the system to support clinical placements and to develop a strategic approach to allocation of clinical placements that ensures both equity and access for students, quality educational outcomes and innovation through collaborative partnerships.

An agreed methodology will account for and apportion the costs and benefits of clinical practicum for all stakeholders and industry partners, so that a sustainable approach to clinical practicum can be established. These are complex issues that require balancing multiple stakeholder agendas.

As nursing is a National Priority Area (NPA) in education for the Australian community, it is essential that additional funding for nursing programs is continued and forms a permanent part of the baseline funding for this discipline cluster, so that the higher education sector (HES) can continue to educate nurses in light of predicted demand.

A more detailed review of the baseline level of funding is merited to arrive at a sustainable funding level that balances the pedagogical needs of students with the regulatory requirements for licensing and the work readiness concerns of employers. Clearly the needs of health consumers should also have a voice in this dialectic. In the complex interface between health and education, it is likely that funding policy will form one strand of a strategic approach to clinical practicum for undergraduate nurses. There would also be benefit in unpacking the complex and interrelated factors driving the spiralling costs of nursing programs.

1. About Recommendation 24

The National Reviews of Nursing Education (2002) Our of Duty Care

Since clinical practicum is an essential element of the preparation of all nurses and an area where the costs have increased to a point of being unsustainable, new quarantined funding over five years should be provided for clinical practicum, in addition to the operating grant for undergraduate nursing courses. It should be administered through a new program, the Clinical Practicum Partnership Program. The program should be formally evaluated in the fourth year to assess its impact and identify any changes that may be required for its continuing operation. The program should meet the following criteria:

a) promote State and Territory-based cooperative arrangements between those sectors preparing nurses for initial registration and those employing them;

b) be acquitted in terms of delivering quality clinical placement outcomes (to defined minimum standards);

c) prioritise partnership arrangements and contributions from all sectors involved in health and education;

d) promote innovative approaches to clinical practicum;

e) include some assistance to students, particularly those who are disadvantaged by the high costs of attending clinical placements.

The National Review of Nursing Education (2002) *Our Duty of Care Report* recognised the vital importance of clinical practicum in nursing and midwifery preparatory education, but also noted the substantial costs associated with providing clinical practicum that meets the standards set by nursing and midwifery regulatory authorities (RAs). **Recommendation 24 Funding for Clinical practicum** recommended that additional funds be devoted to supporting this component of undergraduate education.

The Australian, State and Territory Health Ministers referred the funding aspect of Recommendation 24 to the Commonwealth Minister for Education, Science and Training's Higher Education Review.

The National Nursing and Nursing Education Taskforce (N³ET/the Taskforce) has been asked to give consideration to funding and other mechanisms to achieve the required clinical practicum outcomes in a range of health, community and aged care settings.

As a result of the Higher Education Review, there are over seventy separate reforms under the Commonwealth's *Our Universities: Backing Australia's Future* package, including that nursing has been identified as one of the National Priority Areas (NPA) currently targeted for additional support. Among a raft of measures in support of nursing, an additional $54 million (over 5 years beginning from 2004) has been allocated to undergraduate nursing programs and is specifically to "*be directed towards the costs associated with clinical practicum in nursing…" (Department of Education Science and Training (DEST) 2004*).

The recent Productivity Commission Report into Australia's Health Workforce (2005) has also identified clinical training for all health professionals as a key issue on the national agenda. The report notes that there is currently national activity directed towards maximising the utilisation and outcomes of the clinical component of courses leading to registration for all health professionals, particularly as it is seen as an area that requires investment not only by government and universities, but also by health services from public and private sectors. The Commission advocates for more responsive health education and training that is consistent with Principle 5 of the **National Health Workforce Strategic Framework** (NHWSF) (Australian Health Ministers Council 2004).

The **Council of Australian Governments** (COAG) has responded to this report by prioritising action on the report, including recommendations to look further at options for enhancing clinical training, and the jurisdictions and relevant Commonwealth departments are currently looking at options and opportunities for furthering this work (Council of Australian Governments 2006).

Most recently, in the time immediately prior to the finalisation of this report, and in response to the Productivity Commission report, the Prime Minster of Australia, the Hon John Howard announced (April 8), funding to support an additional 1000 nursing places across Australia (on top of those places created under Backing Australia's Future) commencing from 2007, and an increase in funding for clinical practicum for existing and new student places.

These developments provide the context for this report on clinical education funding.

2. Purpose and scope of the project

The timely coincidence of the Higher Education Review has provided for a swift and welcome response by the Australian Government to Recommendation 24 of the *Our Duty of Care Report*. The role of the Taskforce in this recommendation has been to monitor this response and the outcomes for clinical practicum in nursing and midwifery education, and to inform Ministers of the policy impact.

The purpose of this paper is to report on spending by Australian universities of additional funding for clinical practicum for undergraduate nurses (and midwives) in line with the Commonwealth Our Universities: Backing Australia's Future policy. As directed, in preparing this report consideration has been given to funding and other mechanisms to achieve the required clinical practicum outcomes in a range of health, community and aged care settings.

In formulating this report, the Taskforce recognises that determining the impact of Government funding policy on clinical practicum is inherently problematic. Currently there is concern regarding system capacity to support demand for clinical placements not only for nurses, but also for students in other health disciplines. This is driving a competitive market in clinical placements for students.

It is also widely acknowledged that universities, health service providers both public and private, individuals and clients share the costs of providing clinical practicum. Similarly, it is acknowledged that the parties benefit either directly or indirectly from the clinical component of training. While it is clear that costs of clinical practicum are escalating, however, there is no agreed methodology for costing and apportioning the costs and benefits associated with clinical practicum, or for disaggregating the costs of practicum from the costs of the whole preparatory program.

Our Duty of Care proposed quarantined funding for five years for clinical practicum with an evaluation following the fourth year. This part of the recommendation is superseded by the Our Universities: Backing Australia's Future policy, which provides the vehicle for additional funding to identified National Priority Areas. This report evaluating the impact of additional funding to clinical practicum is occurring in the third year of the policy initiative, in line with the timeframes outlined in the initial work plan and project budget approved by Ministers for the Taskforce.

Given that the policy is newly implemented, the first part of this report focuses on data about the funds received by universities and reported utilisation of these funds in the immediate and short term.

The second part of the report probes further into a number of issues raised by universities in their responses to the Taskforce. This discussion focuses on identifying the factors contributing to the costs of clinical practicum and where there are barriers to, or opportunities to explore new and different, and possibly more cost-effective approaches to achieving professional competence through clinical practicum models.

2.1. What is clinical practicum?

Clinical practice, clinical learning or clinical practicum is an important component of educational programs preparing health professionals, including nurses and midwives, for registration, enrolment and entry to practice (School of Nursing, Flinders University, Adelaide, University of Technology, Sydney et al. 2002), Although this report focuses on the issue of funding clinical practicum for registered nurses and midwives, the issues raised have relevance to enrolled nurses and other health disciplines.

For the purpose of this report, clinical practicum refers to the planned component of the curriculum where students practice skills and consolidate their learning in real practice settings[1].

[1] In the context of higher education, clinical practicum is different to Work In Industry or WEI. Units of study are considered to consist wholly of WEI where the higher education provider (HEP) is not providing direction to a student's learning and performance in regards to work undertaken outside of a provider. Units of study including clinical practicum for learning and assessment attract funding under the CGS, whereas WEI units do not.

As practice-based disciplines, nurses and midwives must demonstrate professional levels of competence to meet the requirements for professional registration and practice. Clinical practicum is therefore a planned part of the preparatory program/curriculum where students develop competence by practising or consolidating and refining newly acquired skills, where they learn to apply theory to practice in real contexts and where they begin to exercise clinical judgment in real and complex situations under guidance, instruction and supervision.

Competence to practice nursing and midwifery is assessed against the Australian Nursing and Midwifery Council (ANMC) competency standards for Registered Nurses and Midwives[2], which reflect the standards agreed by the profession and professional regulators as required for beginner level practice. Further discussion of the ANMC standards is included in Section 4.2.

There is a great deal of professional dialogue, and little agreement about what constitutes ideal clinical practicum in terms of the nature and extent of exposure and the quality of the experience. During clinical practicum, students may engage in a range of activities including observation of clinicians at work, direct patient care (caseload management) under supervision, case studies, simulated and laboratory sessions, discussion groups and tutorials, reflective journaling, research and data collection from records. Students may be assigned a task or skill to master, a caseload within a clinical unit or service area or a group of clients to follow. There is no set formula and no agreement on which learning activities and environments are best suited to developing competence in the different domains of nursing and midwifery practice (School of Nursing Flinders University Adelaide, University of Technology, Sydney et al. 2002).

There is general agreement, however, that a positive experience for students fuels the new graduate's enthusiasm for practice in certain settings and specialty areas. Students who do not experience nursing in certain practice settings, eg. rural and remote settings or mental health services, are less likely to seek employment in those areas. Hence, clinical practicum aids the recruitment of new graduates to the nursing and midwifery workforce (Mahnken 2002; National Review of Nursing Education 2002; Belcher, Kealey et al. 2005; Cleary and Happell 2005; Hayman-White and Happell 2005).

2.2. Nursing and midwifery

The National Review of Nursing Education (2002) *Our Duty of Care Report* uses the terms nurse and nursing to refer to enrolled nurses (ENs or Registered Nurses Division 2 in Victoria), registered nurses and midwives "in whatever capacity they are employed within health, eg. clinical practice, education, management and administration, research, quality, risk management, change management and projects, and government and policy" (p.47).

The Taskforce has been cautious in its response to the recommendations from *Our Duty of Care*, to acknowledge that midwifery is recognised as a distinct professional group within the regulatory frameworks of several jurisdictions. However, in developing this report, it is evident that for the purposes of Commonwealth funding, the Department of Education, Science and Training (DEST) does not distinguish between nursing and midwifery as minor disciplines (see **Appendix 1** for nursing codes that make up the nursing cluster). As this report deals with DEST and university data and Australian Government funding policy, nursing and midwifery are treated as one (combined) discipline group.

In reading this report, it is noteworthy that enrolled nurses (EN or Registered Nurse Division 2 in Victoria) comprise approximately 24% of the RN/EN population[3] of the Australian nursing and midwifery workforce.

[2] The ANMC endorsed the ANMC Competency Standards for Midwives in November 2005; competency standards developed by the Australian College of Midwives Inc have been used as the benchmark for competent midwifery practice prior to this. There are also ANMC competency standards for enrolled nurses and for nurse practitioners.

[3] Derived from 2003/2004 Registrations reported by RAs, and excludes midwives who are not also nurses.

ENs are currently educated in the Vocational Education and Training (VET) sector to either a Certificate IV or Diploma level. Whereas the Australian Government has responsibility for funding higher education, in the current system, the jurisdictions have responsibility for developing local priorities for funding vocational education and training.

In this case, additional Commonwealth funding for undergraduate clinical practicum supports only clinical practicum for undergraduate students of nursing and midwifery in the higher education or university sector and not enrolled nurses.

2.3. Challenges in collecting and interpreting the data

The following methods have been used to generate the information to formulate this report:

- A review of contemporary professional literature (subsequent to the National Review of Nursing Education (2002));
- Context analysis including a mapping of the regulatory requirements of Nursing and Midwifery Regulatory Authorities with respect to the clinical component of courses leading to registration and enrolment;
- Clarification of Government and DEST funding policy, reporting requirements and distribution of funds to universities;
- A survey of universities to clarify the way funds have been allocated and spent to benefit the clinical practicum component of undergraduate nursing programs, and to identify where universities are initiating innovative models or approaches to clinical practicum.

In approaching this recommendation, the Taskforce has been aware that while a clear policy intention is the driver behind additional Commonwealth funding to universities, no additional reporting or accountability requirements are attached to this funding component by DEST. This has informed the largely qualitative nature of the request for information directed to universities and has hampered the collection and reporting of uniform, accurate and complete data by the Taskforce.

It is evident from the variable nature of responses that a comprehensive and complete data set is not achievable with respect to this matter (see discussion of DEST policy in **Section 4.1**). Although there was a high response rate to the survey by Vice Chancellors (VCs), a number of universities reported difficulty in compiling the requested information (as a consequence of DEST policy), and elected to submit data in a range of formats consistent with data already collected by their institution, or to submit commentary on the data items and related issues.

Reported data does, however, provide a "snapshot" or indication of how funding has been used by universities to support clinical practicum. The comments and responses by VCs indicate that there are a number of issues that merit consideration in evaluating the effectiveness of this policy and its impact on the quality and outcomes of clinical practicum.

Notably, the findings also highlight that many universities are implementing, or are keen to explore innovative approaches to clinical practicum programs to make best use of available funds in a dynamic educational environment. This will be discussed further in section 3.3.

3. Utilising additional funds for clinical practicum

To evaluate the impact of additional Commonwealth funds to support nursing clinical practicum, the Taskforce requested information from universities offering undergraduate nursing programs to ascertain how funds had been utilised over time. For the purpose of this report, *clinical practicum funding* refers to this component of the funding provided by DEST for nursing education and *clinical placement* refers to an aliquot of clinical practicum in a service setting.

The survey was directed to the Vice Chancellors (VCs) of Australian universities offering Bachelor of Nursing programs, and requested information on the following:

- The net gain in funding per year (as a dollar value and as a percentage of overall funding) to the university's school of nursing in 2004 and 2005 as a result of additional funding for the support of nursing clinical practicum;
- The ways additional funds for nursing clinical practicum received in 2004 have been utilised, eg. what, if any, new and innovative arrangements have been implemented to support and promote excellence in Bachelor of Nursing clinical practicum programs;
- Whether funds have been, or are to be directed to support clinical practicum in Bachelor of Midwifery (direct entry midwifery) programs;
- The ways funds for nursing clinical placements in 2005 and thereafter will be used to improve the quality and support for Bachelor of Nursing clinical practicum;
- In what ways the impact of additional funding for 2004 and Commonwealth Grant Schemes (CGS) funding for nursing clinical practicum in 2005 and thereafter is to be evaluated.

At the time of the survey, there were 34 higher education providers of nursing programs. Responses were received from all HEPs surveyed (one public higher education provider was omitted from the survey). Details of respondents are in **Appendix 2**.

Not all universities provided responses to all the questions, and as the nature of the inquiry was largely descriptive, the following discussion synthesises the responses and provides an overview of the key issues raised by the respondents.

Several universities could not report on the data items requested, as internal/institutional data collection processes do not provide for disaggregating the funding for clinical practicum for domestic/Commonwealth-supported and full fee-paying students. A number of universities also highlighted methodological difficulties disaggregating funding for the clinical practicum component from the entire nursing program funding.

As incomplete data was received with respect to the first question on the net gain in funding per year, reporting this funding as a percentage of overall funding to the school of nursing has not proved useful to the analysis, as universities report there are multiple other funding components that impact on overall funding and make any figure difficult to interpret. This data has therefore been omitted from the analysis and discussion.

A number of universities provided data, but noted that financial agreements with the DEST were considered confidential, and that any examples or illustrations of financial data should be de-identified. Consequently, the funding data included in this report is either de-identified, or where specific has been sourced from DEST and is public data.

3.1. Net gain per year to schools of nursing (2004 and 2005)

Data received from DEST indicates that in 2004, additional clinical practicum funding dispersed to universities was at a rate of $607 per equivalent full-time student load (EFTSU[4]) based on 2003 student load figures, and was provided as a lump sum mid year. University funding and budgets are generally based on the calendar or academic year.

From 2005, DEST advises that additional funds are merged into the cluster funding or Commonwealth course contribution (CCC) (This is explained further in **section 4.2**).

Table 3.1: DEST funding to public and private higher education providers for nursing in 2005

	Total agreed number of places	Total funding rate	Practicum funding rate	Non-practicum funding rate	Total funding	Total practicum funding	Total non-practicum funding
Public Higher Education Providers Sub-Total	17,621	9,750	659	9,091	171,804,750	11,612,239	160,192,511
Private Higher Education Providers Sub-Total	124	9,750	659	9,091	1,209,000	81,716	1,127,284
GRAND TOTAL	17,745	9,750	659	9,091	173,013,750	11,693,955	161,319,795

Source: Commonwealth Department of Education Science and Training

Table 3.1 (above) shows that in 2005, total funding to universities for nursing was $173,013,750 for a student load of 17,745 (EFTSL[5]). Funding was at a rate of $9750 per EFTSL for institutions that received the 2.5 per cent increase in Commonwealth contributions through compliance with the National Governance Protocols and workplace relations policies. Of this, $11,612,239 ($659 per EFTSL) was to assist with the costs of clinical practicum. **Appendix 3** provides the breakdown of this funding and student numbers for individual universities.

DEST reports that standard indexation has been applied to the Commonwealth contribution for 2006 for all discipline clusters including nursing (Cluster 12), bringing the total funding rate per EFTSL for nursing in 2006 to $9,692, and the clinical component to $688 (**Appendix 5** contains the agreed EFTSL for nursing for individual universities). Taking into account an additional increase of 5%, conditional on compliance with the governance and workplace reform requirements[6], the total funding rate for Cluster 12 in 2006 is $10,176 (per EFTSL). The agreed number of Commonwealth-supported nursing EFTSL for 2006 is 17,914. All universities received the same rate of funding for clinical practicum included as part of the Commonwealth contribution for Cluster 12.

An outcome of the Council of Australian Governments (COAG) meeting on 10 February 2006, and in response to the Productivity Commission report, *Australia's Health Workforce* (2005), is the announcement of a package of measures to address workforce shortages. Measures include increasing the Commonwealth course contribution towards the cost of nurses' clinical training to $1000 per full-time student (April 8, 2006) for existing and new student places. This is equivalent to a 45% increase in the amount of clinical practicum funding for 2006.

[4] EFTSU – Effective full-time student load calculated using student enrolments

[5] EFTSL – Effective full-time student load calculated using student completions. The change in calculations of student load is explained further in section 4.1.

[6] In 2007 the increase for universities complying with governance and workplace reform requirements will be 7.5%.

3.2. Utilisation of additional funding for clinical practicum

This section reports on the utilisation of clinical practicum funding by universities. In responding to the questions posed by the Taskforce, universities have raised a number of issues that impact on the costs of providing nursing clinical practicum. Firstly, it is acknowledged that the issues reported here reflect the views of higher education providers (HEPs), and do not take into account the cost issues related to clinical placements for governments and health services, students or health providers. Broader discussion of the issues follows in the next sections.

Secondly, universities identify that utilisation of additional funding for clinical practicum data needs to be viewed in the context of the total funding to universities for nursing, and take into account factors such as the baseline cluster funding amount and the cap imposed on student contribution. Funding under the Our Universities: Backing Australia's Future Policy is discussed in **section 4**.

Sustainability of nursing education

In responding to this question, most universities welcomed the additional funding for clinical placement but added commentary and clarification to their reporting of utilisation of funds, clearly identifying the sustainability of nursing courses under current conditions as a key issue.

Administrative deductions

From the responses, it is apparent that universities passed on variable amounts of the additional funding in 2004 and thereafter to schools/departments of nursing. For example, one HEP indicated that $405 per EFTSU was passed on to the school of nursing. In contrast, a number of universities reported that the full amount of clinical practicum funding for 2004 had been passed on to the school of nursing, noting that it would be normal practice for the university to deduct an administrative levy or top slice from all funds received.

It was suggested that as funding in 2004 was forwarded as a lump sum mid-year, planning and budgeting for clinical practicum for that year would have been undertaken in 2003, and budget deficits accounted for at that time. Hence this quantum could be passed on to the school of nursing in total for use at the school's discretion.

Other respondents noted that an administrative deduction had been applied to additional clinical practicum funding in line with internal funding policy and processes. Sporadic information was provided about accounting procedure or the size of the administrative slice (up to 32% in some cases). This was not a question field, and not all respondents offered commentary on this issue, so no conclusion can be drawn, except that it would be reasonable to assume that as the clinical practicum funding from 2005 is aggregated into the Commonwealth contribution amount, it is likely to be subject to the administrative deduction (top-slice) from this point.

Baseline funding adequacy

The baseline level of funding for nursing is identified as insufficient to fully cover the costs associated with clinical practicum. Several respondents noted that internal university funding models and processes up to 2004 (and some for 2005) were largely based on the previous DEST discipline weights. Using this system, nursing was weighted 1.6, medicine was weighted 1.9, science 1.7 and arts and business had a weighting of 1.0. Allied health disciplines, such as physiotherapy and podiatry, were weighted 1.7. Comparatively, nursing was considered under-weighted in this system for the requirements of the curriculum.

Several universities commented that using the previous weighted system, additional funding for clinical practicum brought the relative weighting for nursing to 1.7 in 2004; this level was still considered insufficient to cover the actual or real costs of nursing programs at that time. Universities have needed to routinely cross-subsidise (across disciplines and faculties) to meet the costs of providing nursing programs.

In considering this comment, DEST advises that prior to the introduction of the Commonwealth Grant Scheme, the Relative Funding Model (RFM), which was implemented in the early 1990s, was used to affect a ***one-off*** funding adjustment process so that all institutions were funded more equitably, having regard to their education profile (ie. the relative costs of course provision).

The baseline funding level for Cluster 12 in 2005/2006 was similarly identified by a number of HEP as being insufficient to fully cover the costs of providing pre-registration nursing education in line with the standards and requirements of the nursing and midwifery regulatory authorities across Australia, particularly in the context of the escalating costs of providing clinical practicum and a cap on Higher Education Contribution Scheme (HECS) charges for nursing.

Escalating administrative and running costs

Respondents in all jurisdictions identified the escalating costs of clinical practicum as a key barrier to the sustainability of nursing programs in the future.

a) Charges by health service providers

A number of HEPs commented that there was a drive to establish preferred provider relationships (models of clinical practicum) between universities and health service providers (HSPs), to improve the clinical learning environment, experience and outcomes. HSPs are looking for work-ready graduates who are well-orientated to their organisations and preferred provider relationships are seen as a mechanism for recruitment and a means of minimising resources to support graduate transition to work. Such arrangements are, however, driving a competitive market and in turn providing the impetus for HSPs to charge for clinical placements. There was further concern that it was likely increased funding by DEST would trigger a flow on increase in the charges to universities for clinical practicum by HSPs.

This is of most concern for respondents based in QLD, who highlighted that the Clinical Deed (service agreement) between HEPs and Queensland Health services for 2006 stipulates that universities will be charged $30.07 per student per clinical hour for clinical placements. (Note, this cost is uniformly applied to students from other health disciplines undertaking clinical practicum/placements in QLD Health services). It was noted that many private health services had adopted similar policies with respect to charging for clinical placements.

b) Sourcing clinical placements

Smaller and newer HEPs of nursing expressed that the larger, more-established universities and programs had a firm monopoly on clinical placements and in this context it was difficult to break in to the market. This meant that they had to invest resources to source clinical placements in more remote, and often less than ideal, locations. Both students and faculty had to travel further adding to costs. One HEP reported that the university had been unable to access suitable clinical placements for final year students and had been forced to modify the program and replace clinical practicum in service settings with simulated and laboratory practice[7].

[7] Note: Regulatory authorities require HEPs to report substantial modifications to pre-registration programs of this nature for approval.

There is clearly tension between implementing programs with more clinical practicum and ensuring access to practicum opportunities for all students. Similarly, newly established program providers expressed concern that currently there is no centralised agency or mechanism to coordinate the allocation of clinical placements so that all students had access to quality learning environments. There was also a view that distribution of further Commonwealth places for nurses might need to take account of availability of clinical placements.

A number of universities argued that cost increases over the last few years relative to increases in student load was substantial. For example, one VC reported

> …I cannot underestimate the pressure that universities are under with respect to meeting escalating nursing clinical placement costs. Estimates on average an increase of 22% per annum …. Estimates expenditure for 2005 will exceed $2M (an 83% increase in the three years from 2002) in the context of an average growth of 12% p/a in student load (39% for the same three years)… Additional funding is welcome but a significant gap remains …

VCs reported that the cost of programs is increasing more than the standard indexation applied to DEST funding components. Therefore, the amount of subsidisation required is incrementally higher and not offset by the Commonwealth clinical practicum additional funding. On the other hand, there are schools of nursing that are not cross-subsidised, instead operating with high student-to-staff ratios to meet budget targets. Consequently additional clinical practicum funds are being used to "offset budget deficits" and to reduce the amount of cross-discipline subsidisation. In these cases, while a net funding gain to university was reported, this gain was not passed on to schools/departments of nursing as disposable budget.

c) Maintaining relationships

Respondents identified increasing administrative costs related to negotiating contractual arrangements with health services for additional and ongoing clinical placements as an ongoing issue. A number reported that there is an increasing expectation of close liaison and a partnership approach so that clinical practicum meets the pedagogical needs of students in various stages of the pre-registration program and the requirements of regulatory authorities. A number of respondents were in the process of implementing new curricula involving collaborative clinical practicum models. Collaborative models, while offering benefits for all stakeholders, were identified in some cases as adding an additional cost burden in areas such as liaison with and providing supports to the clinical agencies. Additional costs are also incurred in supporting clinical practicum in remote and rural locations eg. faculty travel, effective communications, grants for students to cover travel and living expenses in remote locations.

d) Regulatory requirements for clinical practicum supervision

While it is generally accepted that regulatory authorities have legitimate authority to set the standards and requirements for courses leading to licensing, universities identified that there were significant costs associated with meeting minimum requirements, eg. supervision ratios and other arrangements for students during clinical practicum. Education standards provide for protection of the public. However, the current standards need to be examined in the context of escalating cost and sustainability tensions, and innovations in teaching/learning technology.

e) Legal costs for clinical affiliation

Health services have a responsibility to protect their clients and to ensure safe practice and high care standards in the context of students' clinical practicum. There is often a lengthy negotiation and contractual agreement process whereby the parties agree on rights and responsibilities, fiscal arrangements and indemnification. The legal costs for clinical affiliation agreements escalate the costs of clinical practicum further.

3.3. Clinical practicum improvements/innovation

Despite widespread reservations about the adequacy of the total funding to nursing programs, a number of universities reported the ways funds for clinical practicum were being utilised to improve or enhance the clinical component and outcomes for students.

Responses by universities indicate that HEPs adopt a long-term vision of program development. Their responses to utilisation for 2004 and 2005 and thereafter were similar, and have therefore been reported together in this section.

Additional funding was directed to four main areas of development and improvement: administration support and arranging and contracting for clinical placements; clinical liaison supervision and support for students and health services for clinical practicum; establishing new or improving clinical practicum models; and incorporating additional clinical practicum time into the program. There was considerable overlap and interdependence in these areas. For example, additional funds were use to support items such as:

- Salaries for additional staff in the clinical practicum program eg. clinical coordinators, administration assistants, clinical liaison, clinical teaching staff;
- Travel and accommodation for faculty to liaise and provide support and supervision for students in rural areas;
- Resources for clinicians and academics involved in the clinical program eg. resource materials, preparatory workshops, liaison and consultation activities, ongoing support by faculty for clinical preceptors, professional development programs for preceptors and clinical mentors (fee-free) with credit towards a postgraduate qualification;
- Resources to better equip/prepare students to make the most of clinical practicum eg. clinical labs, upgrading clinical equipment, computer-assisted learning and assessment programs and simulation technology;
- Reporting and monitoring activities, eg. development of evaluation tools, and evaluation of changes to the clinical practice program including evaluation of new positions;
- Planning and administration activities eg. sourcing new clinical placement providers, negotiation of clinical placements and service agreements with HSPs;
- Development, implementation and evaluation of new or improved clinical practicum models (and new curriculum models) such as programs including increased amounts of clinical practicum to facilitate "work readiness". For example, one HEP reported that they were implementing a new bachelor of nursing program with increased clinical practicum hours. It was noted, however, that early evaluation was planned in light of escalating costs of clinical hours and the program might again be subject to revision;

- There was also a focus on devoting resources to development of collaborative clinical practicum models, with different arrangements for clinical supervision and support. There was recognition of the substantial costs associated with developing strong partnerships that meet the needs of all stakeholders;
- Exploration of alternative clinical learning environments and clinical practicum opportunities in a variety of community and residential and aged care services. There was also a focus on exploring greater use of laboratory and simulated practice to develop student competency in preparation for clinical practicum;
- Several universities had allocated sums to assist or provide scholarships or grants to students on clinical placement, particularly those undertaking clinical practicum in remote and rural health service settings. No information on the value of such grants was provided.

It is evident from the range of responses that some of these activities/items would not have been undertaken or possible without additional clinical practicum funding. It is unclear, however, if this is the case for all providers as quality improvement is part of the normal cycle of program evaluation, review and reaccreditation by universities. Itemised breakdown of expenditure was not provided by all respondents.

The focus on developing strong partnerships and collaborative models of clinical practicum was a consistent theme through the responses, as was the focus on improving the experience for students and augmenting work readiness. These themes are consistent with the best practice benchmarks for clinical practicum in nursing programs reported by the Australian Universities Teaching Committee report (2002) (see **section 4.3**). Strengthened partnerships, collaboration and consultation were reported to improve outcomes for students, but were acknowledged as adding to the costs of running clinical practicum programs.

Where funds had been directed to change or improvements, most providers indicated that in the future the clinical practicum component would be directed to continuation of the identified items or evaluation of outcomes.

However, many respondents anticipated further increases in the cost of providing clinical practicum and there was a view that standard indexation to funding by DEST would be insufficient to keep pace with the burgeoning costs around salaries (subsequent to industrial and workplace agreements), charges by HSPs, and the increasing administrative burden. Justification of standards and requirements imposed by regulatory authorities (RAs) in the current context was questioned in some cases, and argument put to review the supporting evidence for such standards.

These issues were represented as posing a serious risk to the sustainability and ongoing viability of pre-registration nursing programs in the future.

3.4. Support of Bachelor of Midwifery clinical practicum

In 2004/2005, six universities offered Bachelor of Midwifery programs (either as a single or dual qualification) leading to licensing as a midwife. The survey inquired if clinical practicum funding was also used to support the clinical practicum component of these programs. The Taskforce is aware that there is interest from a number of HEPs in developing Bachelor of Midwifery programs and several have commenced planning and developing programs.

HEPs reported similar issues driving the costs of providing clinical practicum in Bachelor of Midwifery programs and similar issues with timely access to placements to meet clinical learning needs.

Currently, DEST policy and data rules do not distinguish between the minor disciplines of nursing and midwifery; they are both at this point coded under the discipline of nursing. According to DEST, additional funding may be used to support clinical practicum in any course/unit of study coded as nursing. Despite this, only two providers reported that clinical practicum funding was directed to support clinical practicum in midwifery programs, while the remainder had not utilised funds in this way.

3.5. Impact evaluation

The rationale behind Recommendation 24 from the *Our Duty of Care Report* is to provide adequate funding to support the clinical component of pre-registration programs so that students meet the competency standards required for practice in a range of settings. At the same time, the report recognised the secondary benefits of clinical practicum and the value of providing positive clinical learning experiences and exposure to a range of health service settings.

In approaching the issue of evaluation, the Taskforce acknowledges that as HEPs take a long-term approach to program development, it is unlikely that evaluation at this point in time will be able to rigorously asses the impact of substantial program changes on competency attainment, clinical performance and client management and recruitment and retention. For example, the impact of a program change may not be evident until the cohort of students completes and seeks registration (3 years), although there may be some evidence of impact gained through monitoring attrition and exit interviews. Interim indications of the success of programs can certainly be gained through such measures as satisfaction feedback and by giving diligent attention to the issues raised through partnership processes.

With this in mind, the survey inquired how universities were evaluating the impact or outcomes of additional funds for clinical practicum. Most respondents identified routine approaches to evaluating the impact of additional funds including:

- Student feedback/satisfaction (on-line surveys, end of unit, end of year, end of course);
- Feedback from clinical teaching/supervision/liaison and preceptors;
- Feedback from clinical agencies;
- Budget reconciliation;
- Competency outcomes/student success;
- Completions data;
- Graduate destination survey.

Several HEPs indicated that part of the funding was directed to development of evaluation tools or to funding an evaluation project.

Where substantial program changes were implemented, providers reported that evaluation would be targeted and thorough. However, respondents did not indicate a method of evaluating or exploring the relationship between the clinical practicum model or improvement measures and the attainment of competency and work readiness, or whether certain clinical settings, experiences or activities provided better results in achieving competence in different clinical skill sets or professional domains.

To some extent, this issue is complicated by the ANMC competency standards construct, which focuses on profession competency domains as one of the minimum requirements for licensing. All pre-registration programs must assess against the competency standards, so it is unclear what measure would be appropriate to evaluate a quality improvement in this respect, such as length of time to develop competence, greater work readiness as opposed to beginner-level competence, or the relative cost in relation to achieving competence outcomes through various clinical models. (This will be discussed further in section 4.2).

3.6. Summary of issues

- There are substantial costs associated with providing the clinical component of nursing and midwifery programs for registration.
- Universities have welcomed additional funding to support clinical practicum, but have noted that the total amount of funding for nursing programs has not kept pace with the escalating costs of providing programs that meet regulatory, industry and professional requirements and standards.
- In many cases universities report that additional funds have been used to offset cost increases and that for many, there is a requirement for universities to provide further cross-faculty/disciplinary subsidisation.
- Escalating costs are attributed to factors such as salary increases and enterprise bargaining agreements (EBA), implementation of new approaches to clinical practicum requiring different staffing models, increased costs associated with liaison and administration, charges by health service providers and meeting the requirements of regulatory authorities for courses leading to registration.
- In this context, it is evident that considerable effort and investment is being directed to improving the quality and cost effectiveness of clinical practicum within the overall preparatory program. In most cases, this involves strengthening the relationship between the higher education provider and clinical agency partners to better utilise clinical resources and to improve the quality of the clinical learning experience.
- Despite this, there is clearly tension between providing clinical practicum programs that improve outcomes, work readiness and stakeholder satisfaction and the need for a rational distribution of clinical placements.
- Overall, universities identify the longer-term sustainability and viability of nursing programs as being at risk, should costs associated with clinical practicum continue to escalate.

These issues will be further explored in the next section.

4. Factors influencing the costs of clinical practicum

In their responses to the Taskforce survey, a number of universities identified that while additional funding was welcomed, the total amount of funding for Cluster 12 (Nursing) was not in line with the real or actual costs of providing nursing pre-registration education. In particular, the costs associated with the clinical component of nursing and midwifery programs are escalating at a rate far exceeding standard rates of indexation. Consequently, it was reported that nursing budgets for many providers run at a deficit and require subsidisation through internal university funding mechanisms.

Universities identified a number of interrelated issues as contributing to the escalating costs of providing clinical practicum:

- Regulatory requirements for courses leading to licensing;
- Changes to the clinical practicum model, increasing the clinical practicum component of the program;
- Administrative costs, including costs associated with liaison and maintaining partnerships and relationships.

These issues will be explored in greater depth in this section.

4.1. Current funding arrangements

The Taskforce was directed to consider clinical practicum funding, giving consideration to the outcomes of the Higher Education Review. To understand the costs of nursing education and funding concerns, it is necessary to first locate funding for nursing education in the context of the Australian Government's Higher Education reform program.

Our Universities: Backing Australia's Future

The recent Higher Education Review, *Our Universities: Backing Australia's Future* has resulted in significant changes to the funding and policy framework for universities. Universities derive their funding through a complex policy and funding framework comprised of Commonwealth resources and student contributions available to higher education institutions, (and private sources such as industry partnerships, contracts and entrepreneurial activities). **Appendix 4** shows that Commonwealth resources fall into five categories; core funding, program funding, research funding, student support funding and non-university programs.

The Commonwealth Grant Scheme (CGS or core funding stream) for teaching and scholarship replaced the previous block grants system in 2005. Through the CGS, the Commonwealth provides a contribution, set by discipline, towards the cost of an agreed number of Commonwealth-supported places.

Each higher education institution that receives funds under the CGS enters into a Funding Agreement with the Commonwealth with annual negotiations taking place over the number of places and the discipline mix that the Commonwealth will support. Places to be supported may be at the undergraduate level, the postgraduate non-research level in negotiated fields, and in enabling courses. The Funding Agreement is negotiated in the context of each institution's mission and strategic direction for course provision[8].

The CGS Guidelines make provision (among other things) for a regional loading where universities offer face-to-face courses through eligible campuses outside the mainland capital city. There is also a Medical Student Loading in the CGS to provide funding for teaching hospital costs in a Commonwealth-supported place in a course of study in medicine, completion of which would allow provisional registration as a

[8] DEST website – http://www.dest.gov.au/sectors/higher_education/programmes_funding/general_funding/cgs/default.htm

medical practitioner by an authority of a State, a Territory or the Commonwealth. There is no similar loading to support other health disciplines with a clinical component.

For the purposes of administering the CGS, units of study offered by HEPs are classified into funding clusters, defined by the field of education (FOE) under the Australian Bureau of Statistics (ABS) Australian Standard Classification of Education (ASCED). Nursing (which includes midwifery) comprises **Cluster 12**.

Nursing as a National Priority Area

In 2004, as part of the Backing Australia's Future policy, nursing was identified as one of two (the other being teaching) National Priority Areas targeted for additional support as a mechanism to allow the Australian government to respond to areas of labour market shortage. The range of support measures include:

- Increased Commonwealth course contributions;
- Setting of lower student contribution ranges;
- Provision of additional places by public HEPs;
- Provision of places by private HEPs.

Undergraduate nursing education has since been supported through a range of Australian Government initiatives and programs, including:

- Funding to create more than 4,000 new nursing places, including 1,200 aged care nursing places over four years between 2005 and 2008, and places in private education institutions;
- An additional $54 million over five years (commencing 2004) towards the costs of clinical placements for nursing undergraduates;
- The Higher Education Contribution Scheme (HECS) for nurses was capped at the lowest level[9];
- In addition, the Rural and Remote Nurse Scholarship Program and the Aged Care Nursing Scholarship Scheme were introduced by the Australian Government under a range of policy initiatives, to attract and retain nurses in the profession, particularly in aged care and in rural and remote areas. The two programs include scholarships and support mechanisms for **undergraduate students**, postgraduate and continuing professional development activities for existing nurses, and nurse re-entry and up-skilling opportunities.

In response to the issues raised in the Productivity Commission report on Australia's Health Workforce (2006), the Australian Government has since announced (April 8) funding for an additional 1000 new higher education nursing places a year commencing in 2007, and an increase in the component of clinical practicum funding to $1000 per full-time student for all existing and new places, an increase of $312 or 45% on the clinical practicum funding component (only) for 2006 under the Backing Australia's Future policy[10]. While this amount exceeds anticipated standard indexing, the relative funding for the nursing cluster remains lower than that for other health disciplines (see Table 4.1 below).

[9] Universities may charge fees in addition to HECS, up to 35% above the HECS schedule - http://www.dest.gov.au/NR/rdonlyres/95FCFC22-138C-4EFE-8DB6-C5018E1B185D/8183/aip1.pdf

[10] The policy with respect to duration of increased funding for clinical practicum is not clear at this point.

Funding agreements

Funding Agreements between universities and the Commonwealth set out the conditions on which the Commonwealth will fund universities for learning and teaching and are part of a broader accountability framework, the Institutional Assessment Framework. Funding Agreements include an agreed Cluster Profile for funding under the CGS[11]. Conditions include that universities must:

- provide the agreed number of places; and
- utilise funds specified for priority disciplines such as nursing, including places specified for aged care nursing and regional (campus) allocations, if specified.

The 2006 Funding Agreements between the Australian Government and Higher Education Providers stipulates the following:

> … The Commonwealth Grant Scheme cluster funding for nursing and education include amounts in recognition of the costs of nursing clinical placement and teaching practicum … The higher education provider must use these amounts only for those purposes…

While the policy for utilisation of additional funding for clinical placement is clearly articulated in the Funding Agreement (above), there is no reporting requirement specific to the funding for practicum. Beyond the requirements (above), universities may disperse these funds internally in accordance with university funding policy and processes and priorities. For example, it is normal practice for university funding processes to take a top slice from all funds received except where otherwise specified, for university administration and infrastructure. It is also normal practice for cross-faculty/discipline subsidization of priority programs.

Funding policy outcomes

It is clear from responses to the Taskforce survey that universities utilize these funds in various ways to support the clinical practicum component of courses. However, respondents strongly argued that the total funding to nursing programs is inadequate to meet the full costs of providing programs, hence subsidisation at the institutional level is required.

While nursing as a National Priority Area has attracted additional support, these measures combined have added pressure on universities in providing clinical practicum for nursing programs. For example, additional nursing places while required to meet future workforce needs, have increased the demand for clinical placements where there is already pressure on the system. Universities have argued that this is contributing to the impetus for HSPs to charge or increase charges for clinical placements. While it is likely that the planned increase to clinical practicum funding will ease the burden on nursing budgets, it is also foreseeable that there may be additional costs to universities managing larger student numbers.

Universities have argued that the cap on student contributions for nursing has unintended consequences that merit consideration. (**Appendix 7** shows the funding clusters for 2005 and 2006 and the amounts of Commonwealth course contribution (CCC) for each cluster, noting that the data in this appendix is for students and does not include loadings for compliance with governance and workplace reform.) In 2006, Nursing constitutes Cluster 12 with a CCC of $9,692, which includes the funding allocation for clinical practicum. Medicine is in Cluster 9 and attracts a CCC of $15,332. Health sciences, which include allied health programs such as physiotherapy and podiatry, are in Cluster 6 with a CCC of $7,349 (figures exclude loadings).

[11] The Commonwealth Grant Scheme Guidelines provide the formulas for calculating regional loadings, medical student loading, enabling loading, increases in assistance for providers meeting other requirements (eg. National Governance Protocols), adjustments for providers of places in national priority areas, and adjustments for course assurance arrangements.

As previously discussed, core funding for education comes principally through the Commonwealth Grant Scheme (CGS), plus loadings, and student contribution/HECS liabilities. The HECS schedule is set by the *Commonwealth Education Act 2005*. Universities may charge additional student contributions up to 25% above the baseline HECS. As a National Priority Area (NPA) the student contribution is capped at the lowest rate for courses/subjects coded as nursing; $0 – $3,920 for 2006. To clarify this point, it is noted that in practice, nursing programs often incorporate courses/subjects delivered by other disciplines, which may be subject to an additional student contribution (**Appendix 6** includes a selection of universities and shows the HECS charges and charges above the baseline HECS). This is not unique to nursing programs, and reflects a cost-efficient approach to delivering programs, which draws on complex cross-discipline elements.

Capped higher education contribution is intended to provide incentive to students to commence and complete a Bachelor of Nursing program. However, universities report that the cap also limits funding available to nursing programs, and this in turn limits the potential for program development, change and innovation, eg. the amount of clinical practicum that can be incorporated. Table 4.1 (below) illustrating the baseline core funding for three health discipline areas, shows that the Commonwealth contribution and student contribution, combined provide less income for nursing programs compared to other health discipline programs. (**Appendix 8** shows the student contribution bands and ranges for various discipline areas.) These examples are based on the assumption that all course components are coded for the respective discipline cluster.

Table 4.1: Core funding for health streams

Health discipline	Commonwealth contribution 2006	Commonwealth contribution 2006 +5% compliance load	Student contribution range 2006 for post 2005 students	Total (Commonwealth contribution +5% + maximum student contribution)
Nursing	$9,692	$10,176 (includes additional funding for clinical practicum)	$0 – 3,920	$14,096
Medicine	$15,332	$19,099	$0 – 8,170	$27,269
Health, (includes allied health disciplines)	$7,349	$7,716	$0- 6,979	$14,775

Figures drawn from the DEST Going to Uni website

http://www.goingtouni.gov.au/Main/FeesLoansAndScholarships/Undergraduate/Default.htm

Note: 5% loading has been added to the Commonwealth contribution for compliance with Governance and Workplace relations protocols.

Note: These amounts are indexed each year.

There is an argument that funding clusters have been formulated based on historical understandings of the cost of providing typical programs and includes provision for numbers of clinical practicum hours. However there is evidence that many providers are increasing the clinical practicum component of nursing programs to meet the needs of employers for new graduates who are work-ready (eg. The QUT program incorporates 1700 clinical hours). There is agreement that industry expectations are a strong driver of entry to practice education. Education funding is currently not keeping pace.

It is also noted that as DEST funding for clinical practicum is based on EFTSL (a measure of completions, based on nursing coded components of the course), and clinical practicum costs/charges apply to student numbers (persons or headcount), the funding is further diluted.

With escalating costs associated with providing the clinical practicum, and financial sustainability identified as a risk to programs, there is strong foundation for reviewing the Commonwealth contribution for this NPA, with a view to increasing the amount to support the full costs of nursing programs that meet industry, professional and regulatory requirements.

4.2. Nursing and midwifery regulatory authority requirements for pre-registration programs

Several universities identified regulatory standards for courses leading to accreditation, and particularly the requirements for clinical practicum as contributors to the cost of providing nursing programs. In this context, the regulatory requirements for programs leading to licensing merit further consideration.

Nursing is one of the regulated health professions in Australia. Currently, the eight State and Territory RAs have legislated responsibility/authority to endorse or approve programs of study (and program providers) for the purposes of licensing (registration, enrolment and other authorisations). (**Appendix 9** provides a summary of the legislative head of power.) This function is similar to the functions of other regulatory authorities for health professionals in Australia.

To perform this function, the RAs have developed principles, standards and/or guidelines for the accreditation of nursing programs in each jurisdiction. While there are many similarities, there are currently no nationally-agreed standards to bring uniformity to the process and requirements. This is in contrast to medicine for example, where despite having eight regulatory authorities, one body is responsible for accrediting all programs leading to medical registration.

The issue of fragmented approaches to course accreditation has been raised by the Productivity Commission in the Australia's Health Workforce (2005) and identified by COAG as an area for priority consideration. The Productivity Commission report puts the position that "… a mechanism for the national accreditation (however titled) of courses for health professionals would bring greater uniformity to the requirements and standards…" for entry to practice for health professionals.

It should be noted that at the time of this report, the Australian Nursing and Midwifery Council (ANMC) was in the early stages of a project to develop national standards for the accreditation of courses leading to registration and enrolment in nursing. This project was commenced with a view to the regulatory authorities accepting a national framework of principles and evidence-based standards for implementation in the jurisdictions by December 2006. The intention is to bring uniformity to the outcomes of educational programs for licensing purposes, thereby streamlining mutual recognition of nurses and midwives and promoting fairness, transparency, and a mobile and responsive nursing and midwifery workforce.

Program accreditation principles, standards and guidelines

Pre-registration students of nursing are not regulated in Australia. The purpose of regulatory standards for preparatory courses is to ensure that graduates meet the requirements for licensing or entry to practice. This in turn provides the Australian public with confidence in nurses and midwives and their professional practice. A secondary purpose is to ensure optimal educational conditions to facilitate student learning and attainment of competencies required for licensing.

RA course accreditation standards, principles or guidelines address elements such as:

- Length of course and Australian Qualification Framework (AQF) level
- Substantive content areas
- Prescriptions about clinical practicum including the amount of clinical, setting for clinical
- Assessment requirements and course outcomes
- Infrastructure requirements of course providers
- Staffing requirements including requirements for teaching and supervision
- Governance, administrative processes, and information to users
- Fairness, quality and risk management

With respect to clinical practicum, these standards involve clinical hours and the types of practice settings that students are required to experience to achieve and demonstrate competence, assessment criteria and supervisory arrangements for positive educational outcomes for students.

RAs are not directly responsible for the safety of clients/patients when students are undertaking clinical practicum. This responsibility lies with HSPs, although course standards contribute to managing the risks, eg. by providing safe supervision arrangements. Standards may also stipulate other conditions required by employers or under legislation for the protection of patients, such as police criminal checks and routine immunisations.

Recent mapping of regulatory provisions and processes undertaken by the Taskforce demonstrates that there are inconsistencies in some of the standards that are applied by regulators in the States/Territories that have cost implications for nursing education. Table 4.2 summarises some of the key findings from the regulatory mapping.

Table 4.2: Standards for Course Accreditation for (RN) Pre-registration Programs

Fees and administration
• In some jurisdictions a fee is applied by the RA for the accreditation of courses leading to registration. • There are substantial evidence requirements by some regulatory authorities and varying levels of scrutiny and compliance auditing by RAs.
Minimum qualifications for registration and enrolment
• At present only three RAs stipulate that the pre-registration program is to be a six-semester Bachelor of Nursing program. Currently this is an industry standard and one supported by *Our Duty of Care*; all accredited pre-registration programs meet this criteria, noting that there are also programs developed for graduate entrants and enrolled nurses that, either through credit arrangements (RPL) or program design are condensed to two years. NSW has one accredited Masters of Nursing pre-registration program which exceeds minimum requirements. • In the jurisdictions where direct entry to midwifery is authorised, the minimum requirement is a three-year Bachelor of Midwifery program (noting that in some states the minimum requirement is a post-graduate diploma).
Substantive content
• At present, all pre-registration nursing programs provide a comprehensive curriculum/preparation (although this is variously described). Comprehensive curriculum refers to a curriculum that prepares registered nurses for competent beginner level practice with a range of client groups (across the life span) in the range of contexts and settings where nurses work and includes focus on acute medical surgical nursing, community, aged care, mental health and indigenous health[12].

[12] The comprehensive preparation of registered nurses has been supported by the Health Ministers in their response to the recommendations of the Our Duty of Care Report (2002). Recent Commonwealth Government policy provides for funding additional places for RN programs with a mental health or aged care focus.

- Specific or substantive hours for theory, simulation and laboratory learning are not stipulated by seven RAs. However, several RAs are prescriptive about proportions devoted to each content area and this may have implications for the amount of clinical practicum in particular service setting. Victoria, for example, requires at least 15% of the program to be devoted to Aged Care, 15% to mental health and a minimum 39-hour subject devoted to indigenous health. WA also requires a discrete unit on Indigenous health.

Clinical practicum

- Universities are responsible for arranging suitable clinical placement for students that meet the clinical and course outcomes. RA standards may stipulate the responsibilities of health services with respect to providing clinical placements.
- Five of the eight RAs do not prescribe or stipulate clinical hours, but do require sufficient clinical practicum to meet the course objectives and learning outcomes. NT and Vic require 35 - 40% of an undergraduate nursing curriculum to be comprised of clinical practicum in "real" health service settings (excludes laboratory and simulated learning). In practice, clinical practicum hours vary from 800 to 1700 hours across universities and jurisdictions. It is noted that most providers exceed minimum requirements where stipulated.
- Course providers are required to make suitable arrangements for supervision of students on clinical placements. In some jurisdictions (NT and Vic), supervision ratios are set at 1:8 where clinical teachers provide instruction and supervision for students, although there are increasing numbers of courses that now have in place different supervision models (mentorship, preceptor programs, clinician supervision, clinical facilitators, clinical coaches etc) requiring different levels of input from faculty. Victoria also stipulates a 1:1 preceptor: student ratio. In NSW, the 1:8 ratio is a guide only.
- Students are generally supernumerary while on clinical practicum, although this is not a specified requirement of four RAs (NT, QLD, Tas, Vic).
- Some RAs make additional requirements about clinical practicum; eg. students may not be permitted to do clinical practicum during weekends and night duty.

Assessment of clinical

- In general, RAs report that pre-registration nursing students must demonstrate the ANMC competency standards for registered nurses and the ANMC competency standards for Midwives for Bachelor of Midwifery students to be eligible for registration (although this is somewhat ambiguous in the case of NSW), and education providers are required to make a statement to the RA to that effect.
- For the most part, RA standards/guidelines do not focus on articulating the detail of nursing knowledge (eg. nursing management of people with respiratory conditions) or practice skills (eg. inserting an indwelling urinary catheter). Rather, they articulate the high level skills, knowledge and attitudes expected of registered nurses and midwives at entry to practice, ie. how the nurse or midwife is expected to practice and his/her capacity to practice. They are the minimum standards required by all who seek authorisation to practice as a nurse or midwife in Australia. An explanation of the ANMC competencies is included in **Appendix 10**.
- Assessment tasks are pitched at the level of critical thinking and autonomous practice required at a level 7 (Bachelor degree) in the Australian Qualifications Framework (AQF), although the AQF level is not specified in RA standards for 5 jurisdictions.

Accreditation cycle

- Programs and training providers are generally accredited for a limited period, eg. five years in NT, QLD and Tasmania, after which time the program must be reaccredited.
- Note: to meet the internal quality standards for universities, which are self-accrediting organisations, programs must also be approved through internal university processes.
- Any change to a program in content, curriculum design, mode of delivery or assessment must have the approval of the regulatory authority.
- With the exception of the ACT, the RA in the jurisdiction in which a program is offered must approve the program developed by a university for delivery in that state. While this is a legislated responsibility for RAs, the current system poses barriers to universities offering courses across State/Territory Boards or through the *virtual university*.

Analysis of the mapping also indicates that for the most part, there is little contemporary robust evidence to support many of the standards in place (eg. 1:8 supervision ratios, minimum clinical hours). Mostly, they have evolved through years of experience, custom and practice and in response to industry/professional expectation. An example of this is where, in response to union pressures, there are restrictions on clinical practicum during night duty or weekend shifts. This problem is not unique to nursing, but is indeed a common finding of standards developed for health professional education in a range of disciplines (Human Capital Alliance 2005).

In making this point, the Taskforce's view is that standards for education programs are necessary, but should be based on sound evidence and, in order to promote mutual recognition, should be uniform across all jurisdictions. Standards for preparatory programs should be viewed as part of the broader regulatory framework providing protection of public safety, and the public interest (The latter is a slightly broader concept that takes issues such as community need, access to programs and impact on workforce into account). Therefore, regulatory standards for courses should be consistent with the principles of National Competition Policy. They should be warranted in the public interest, and should not be for the protection of professional interests. On balance, the benefits should outweigh the burdens of regulation and such standards should be practical, achievable and where necessary, enforceable.

This argument should not be used to dismiss existing standards. However, without evidence to support alternatives, but should focus examination on whether indeed there would be benefit in having greater flexibility and discretion, principle-based or outcome-based standards.

Clearly, there is a case for further research into standards for pre-registration programs that provide for flexible learning arrangements, reasonable use of innovative teaching and learning technologies and methodologies, and that do not impose unwarranted restrictions on teaching and learning or pose unrealistic standards for entry to practice. Research should however be considered in the context of national work and directions arising in response to the Report (2005).

Clinical outcomes: competency to practice v work readiness

A number of universities have identified that they have increased, or are planning to increase the clinical practicum component of the pre-registration program. In the absence of national standards, there is certainly evidence of a broad range of clinical practicum hours across Australia (from 800 to 1700), and where set by RAs, many programs exceed minimum requirements. Historical benchmarks of 40–45% clinical practicum are fast being superseded by industry expectation that clinical practicum should generate new graduates who are work ready, indicating a tension/dislocation between current regulatory standards and industry requirements. In turn, this highlights the issue of how regulatory requirements for entry to practice (programs) are formulated and validated.

Regulatory authorities require evidence of achieving the ANMC competencies standards for licensing. The ANMC competency standards are structured into professional domains (see **Appendix 10**) rather than discrete clinical skills or tasks as indicators of competence. ANMC contends that the standards provide the detail of the professional attributes, skills, knowledge and attitudes expected of registered nurses and midwives at entry to practice, ie. *how* the nurse or midwife is expected to practice and his/her capacity to practice. These competencies have application to diverse nursing roles in a range of health service settings and with a variety of clients/groups.

The ANMC competencies for registered nurses were revised in 2005 through a national consultative process and all regulatory authorities have endorsed the revised version, which is substantially unchanged. However, while they constitute the agreed benchmark of competency for registration (licensing), there is ongoing tension and dialogue regarding whether new graduates who meet the ANMC competency requirements for practice are sufficiently "work ready".

Employer groups, for example, voice concern that new graduates are not ready to "hit the ground running", that they need close supervision, mentoring and support to develop safe practice in some basic skills areas. Providing support through graduate nurse or transition programs has cost implications for employers, and government support for these programs does not usually extend to private HSPs. The expectation of employers is that work readiness should be reflected in the standards for licensing and in courses for that purpose. More clinical practicum is proposed as the solution. However, at present, there is insufficient evidence that work readiness is enhanced by more clinical practicum.

Employer groups similarly report that the ANMC competencies are complex, difficult to understand and do not resonate with the demands of contemporary clinical practicum. Ideally employers want assurances that new graduates have core skills sets and can safely perform basic nursing functions. This in itself is problematic as the pre-registration nursing program is intended to prepare new graduates with the competencies for beginner level practice in a range of service settings, and the core clinical skills sets for each setting (as distinct from ANMC competences) may be substantially different. For example, in acute health, care core skills might include using "high tech" medical devices, while in mental health the new graduate might be expected to have highly-tuned communication skills. Similarly, in a remote or rural setting, core skills might include procedures such as primary health assessment. A student might be introduced to all these skill sets in their pre-registration program, but would need supervision and direction to develop the skill set in clinical practice.

This issue is the subject of intense interest, and work is progressing in several jurisdictions to better understand the changing work needs of employers. For example, in Victoria, the Department of Human Services "Prepare Nurses for the Future" project is bringing key stakeholders together to discuss and find resolutions for a number of issues in nursing education, including whether there should be prescribed clinical skills outcomes to complement the ANMC professional competencies. There are, however, concerns from some stakeholders involved in the process, that workforce and employer agendas are dominating the outcomes and directions arising from this process.

The Taskforce considers that in the current context, employer expectation should be weighed carefully against the cost implications of increasing clinical practicum to form realistic expectations around the conduct and outcomes of clinical practicum. Similarly, customising pre-registration programs to focus on the skills sets of one service provider, sector/setting, client or specialty group may limit flexibility of the workforce and employment opportunities for new graduates.

New graduates should be viewed as competent beginners only, not experts. Their pre-registration education equips them with foundational knowledge, professional attitudes and essential skills that are both transferable and a firm base on which to build. They have acquired the cognitive, academic and research skills to continue to learn and develop in their chosen discipline.

It is well accepted that to make the transition to employment and to further develop professionally, new graduates require appropriate induction and orientation, access to more experienced nurses for supervision and instruction, peer support, mentoring and introduction to specific clinical and workplace requirements (Johnstone and Kanitsaki 2003), (Adelaide University 2001). Beginners in other professions and health disciplines need similar mentoring; coaching, support and supervision to further develop their skills and confidence to practice safely, independently and to manage more complex situations. For example, medical graduates have internship programs. This is also the case for other professional groups such as lawyers, who complete an *article clerk* year/program following graduation.

It is acknowledged that a key issue for employers is that nurses comprise the largest part of the health workforce, and in many health services the cost of orienting and providing support to new graduate nurses is considerable. Currently, health service providers and governments recognise the value of investing in new graduates, and do this mostly through structured transition programs or graduate nurse programs aimed at assisting new graduates to consolidate knowledge and skills that have direct application to clinical practice, and to further develop their ability to problem solve and make clinical decisions with confidence (Queensland Nursing Council, 2001; DHS Victoria, 2003). That is, jurisdictions and employers take on the burden of bridging the performance gap between new beginner and confident independent practitioner and they in turn reap the benefits. Shifting the emphasis of pre-registration eduction from *beginner* to *work-ready* shifts this cost from jurisdictions (health) to the Commonwealth (DEST/education)[13].

The cost-shifting argument is a difficult one to resolve, given that current costing frameworks do not account for the benefits of clinical practicum for employers. In the absence of a rigorous and agreed way of costing clinical practicum, there is compelling argument to continue State/Territory Government funding to support new graduates and to mitigate employer expectations, so that unrealistic and unsustainable performance outcomes are not expected of undergraduate programs, thereby providing some containment of clinical practicum costs.

4.3. Administrative costs

Access to clinical practicum placements in a competitive environment

The range of clinical practicum hours in pre-registration programs and a lack of evidence to support the various pedagogical approaches to achieving competency outcomes complicate the issue of access to clinical placements. All universities report that they struggle to provide sufficient clinical placements for their students, and that considerable cost is attached to administering the clinical component including accessing, negotiating and contracting for the clinical placements (Australian Government Productivity Commission 2005). Conversely, HSPs identify many reasons for their inability to provide clinical placements, eg. organisational restructuring, staffing models and changes to work flow patterns.

This is particularly pertinent to the nursing discipline, which is the largest health discipline group in Australia and has the largest and most dispersed training base. At the time of this report, there were more than thirty HEPs of nursing and midwifery programs (see **Appendix 2**). The most recent data from DEST[14] indicates that in 2004 across Australia, 8,354 students commenced nursing courses leading to registration, an increase of 1.7% from the previous year, and 23,547 students (total persons taking into account full-time, part-time and multi-modal attendance) were enrolled in courses leading to nursing registration, a rise of 3.0% from 2003. At the time of formulating this report, this data series was not available for 2005-2006 (Department of Education Science and Training 2005).

[13] Our Duty of Care supported the ongoing provision and funding of transition programs for new graduates.

[14] DEST reports midyear on the previous year's commencements, completions and enrolments for major and minor disciplines. For reporting purposes Midwifery load is generally coded by universities as nursing. Note, commencements and completions data is different to student load (EFTSL) coded as nursing.

Table 4.3: Total domestic enrolments, commencements in courses leading to registration in 2004

Commencements and enrolments for 2004										
	Internal			External			Multi-modal			
	Full-time	Part-time	Sub-total	Full-time	Part-time	Sub-total	Full-time	Part-time	Sub-total	Persons
Table 61*. Commencing Domestic Students Enrolled in Courses for Initial Registration as Nurses by State, Institution, Mode of Attendance, Type of Attendance, 2004										
TOTAL 2004	**5,973**	**1,030**	**7,003**	**224**	**438**	**662**	**457**	**232**	**689**	**8,354**
TOTAL 2003	5,989	1,219	7,208	245	396	641	296	69	365	8,214
% Change on 2003	-0.3%	-15.5%	-2.8%	-8.6%	10.6%	3.3%	54.4%	236.2%	88.8%	1.7%
Table 63*. All Domestic Students Enrolled in Courses for Initial Registration as Nurses by State, Institution, Mode of Attendance, Type of Attendance, 2004										
TOTAL 2004	**15,043**	**3,322**	**18,365**	**589**	**1,143**	**1,732**	**3,285**	**872**	**4,157**	**24,254**
TOTAL 2003	14,724	3,338	18,062	1,002	1,222	2,224	2,766	495	3,261	23,547
% Change on 2003	2.2%	-0.5%	1.7%	-41.2%	-6.5%	-22.1%	18.8%	76.2%	27.5%	3.0%

* Reproduced from the DEST Student Statistics series for 2004, which was the most current DEST data at the time of this report. Appendix 11 gives further information about the distribution of enrolments by State, institution, mode of attendance and type of attendance and gender.

The volume of students undertaking nursing studies (and additional new places for nurses commencing in 2007), indicates the increasing pressure on HEPs and their industry partners to provide clinical learning opportunities that meet both the educational needs of students and HEPs, and the requirements of regulatory authorities, without overburdening clinical facilities and their staff and patients[15].

Universities have often reported that they are "at the mercy" of HSPs who renege on commitments to provide clinical placements. Without completion of the required clinical placement hours (as stipulated in the accredited course), completing students may be ineligible for registration. Health services, on the other hand, argue that supporting clinical placements is costly and burdensome for the organisation and for clinical staff, and needs to be controlled and limited to ensure sustainability. Availability of clinical placements may also alter as health services adopt flexible and innovative approaches to patient and workflow management, making it difficult to commit definitively to placements.

There is also a view that regulatory authorities place restrictions on when clinical placement can or cannot be undertaken (for example, not on night duty or weekends), although regulatory mapping indicates that some restrictions are perpetuated through custom and practice.

It is clear that there is a competitive market for clinical placements, and that increasingly financial and other types of service agreements and collaborative partnerships are being used to bring greater certainty to clinical placement availability and the quality of the clinical experience. However, in a competitive market, health service providers also have greater power to charge fees to offset the costs incurred by the organisation for providing support for students, and to negotiate conditions in their favour. The more established HEPs have the competitive edge; newly established schools of nursing with fewer resources report difficulty breaking into the marketplace despite predictions of nursing shortfalls in the future and argue that their students are disadvantaged.

[15] In 2004, there were more nursing students enrolled (24,254) than all other health disciplines combined (37,691 - 24,254 = 13,437).

A number of HEPs have identified that a centralised mechanism for the optimal management of clinical placements would be of benefit and would ensure access to quality clinical placements for all nursing students. There is an alternative view, that a centralised arrangement would unravel and undermine the benefits of strong collaborative arrangements.

There is also a need to examine the evidence and rationale in support of regulatory requirements that restrict the optimal utilisation of clinical resources and explore alternative approaches to clinical practicum that meet the needs of all stakeholders.

The Productivity Commission report (2005) notes that there is currently national activity directed towards maximising the utilisation and outcomes of the clinical component of courses leading to registration for all health professionals, particularly as it is seen as an area that requires investment, not only by government and universities, but also by health services from public and private sectors. For example, a number of jurisdictions are investigating how to efficiently manage clinical practicum placements for all health professionals and there is interest in establishing centralised clinical placement agencies in each state to coordinate placements.

A recent study by Monash University for the Department of Human Services, Victoria (2005) reports on international approaches to undergraduate clinical training for health professionals. The Monash report suggests a number of strategies for optimising the use of clinical practicum resources including;

- adopting outcomes as the basis for accreditation of courses rather than process or model;
- elimination of requirements in excess of the accreditation minimum requirements; and
- use of alternative practice settings where this learning experience is sufficient (eg. simulation labs, clinical labs, community settings and clinics and aged care services).

The report concludes that further research is needed to understand which skills are best taught in which setting/venue.

Liaison, ongoing support, supervision and the clinical model

Despite limited funding, universities report that they are channelling resources into developing and maintaining relationships with HSPs to support clinical learning for undergraduates and other collaborative clinical and academic activities (eg. clinical research). Many are pursuing preferred provider relationships and entering into service agreements that clarify the responsibilities of each partner. There are growing numbers of Clinical Chairs (some of which are jointly funded or partially funded by government) and clinical schools (along similar models to medicine), and HEPs are focusing on using limited resources to support clinicians in their educational role with students. New liaison and support roles are being implemented to promote collaboration and to ensure mutual benefit.

While not specifically noted, most reported program developments of this nature are in line with the best practice benchmarks for clinical practicum proposed in the Australian Universities Teaching Committee (AUTC) report into Learning Outcomes and Curriculum Development in Major Disciplines: Nursing (2002).

The AUTC project aimed to improve teaching and learning across the discipline of nursing (one of a number of projects in major disciplines). The project undertook an extensive exploration to locate best practice in nursing curricula, clinical practicum, recruitment, retention and transition of undergraduate nurses to practice.

A key finding of the project is that quality of clinical practicum is profoundly affected by the state of the partnership between the health service and the HEP. The final report concluded that there is insufficient evidence for the selection of one best practice model for clinical practicum (Clare et al. 2002). However, models involving genuine partnerships between clinical agencies and the university, where student learning is central and valued and where academics and clinicians are well prepared to meet the objectives of student placements, provide a quality learning environment (Clare et al. 2002, p. 6).

Our Duty of Care Report (2002) similarly argued that strong links between theory and practice are achieved when academic educators and practitioners jointly design students' clinical experiences, and the experiences take place in the practice context (National Review of Nursing Education 2002).

A second phase of the AUTC project aimed to identify the elements of such alliances that optimise clinical learning and specifically identify areas of policy and work practice requiring reorientation to better manage clinical learning environments for undergraduate nurses (It is noted that at the time of formulating the report, there were no direct-entry midwifery programs in progress).

The AUTC report summarised best practice for undergraduate clinical practicum as including:

- open and accurate communication between all parties involved in teaching and learning;
- quality preceptorship of students for each placement;
- quality mentoring and role-modeling by experienced registered nurses;
- adequate orientation to each new area of practice;
- an environment of practical realism that linked theory and practice by:
  - clear delineation of graduate requirements using ANCI (now the ANMC) competencies
  - articulation of specific learning goals by the university and the nursing student
  - development of opportunities to achieve practical and cognitive competence in varied skills;
- consolidated clinical learning experiences for continuity of process learning;
- appropriate collaborative assessment of students' clinical learning;
- continuing development and use of innovative clinical practicum models that promote teaching and facilitate learning;
- responsive evaluation of the clinical learning environment to ensure its adequacy to teach students (Clare et al. 2003, p. 19).

The principal outcome of this project was the identification of six national best practice benchmarks for successful partnerships between universities and health care agencies (Clare et al. 2003):

- Partners will develop a shared formal agreement between a university and a health service regarding clinical practicum of undergraduate nurses.
- There is effective and timely communication between partners.
- The rights, roles and responsibilities of persons at every level of the clinical learning partnerships are clearly defined.

- Scholarly teaching by both partners occurs in the clinical learning environment.
- The partnership elements that promote high quality learning for students are provided within the clinical learning environment.
- There is regular monitoring of agreed partnership elements that affect learning, teaching and progress of students (Clare et al. 2003, pp. 57-65).[16]

Since publication of the AUTC report, there is evidence of broad uptake of these benchmarks and principles. (The lag time in implementation for some HEPs is likely to reflect the accreditation cycles of both universities and regulators). The report, however, does not give advice about how these principles might be operationalised, so currently there is substantial variation in clinical practicum models, particularly with respect to clinical supervision arrangements, staffing arrangements to support these models, the amount of clinical required for achieving competence and suitable clinical learning settings. There is a growing trend away from traditional clinical teaching arrangements (1:8) to models that facilitate more innovative approaches to utilising the skills and expertise of clinicians in the education of nurses.

4.4. Apportioning the cost of clinical practicum

At the same time that universities are channeling additional resources to clinical practicum for nurses, increasing attention is being directed to identifying the direct and indirect costs related to clinical practicum for each of the key players, and to agreeing on how the costs should be apportioned.

As with all practice-based disciplines within the higher education sector (HES), nursing schools/departments are faced with the challenge of economically delivering programs with practical components. It is generally agreed that education/training providers, students, clinical agencies and their staff, and patients share the overall costs of teaching and training and also share the benefits. For example, students develop competency through clinical practicum. They are also exposed to a range of employment settings and the realities of professional practice. Universities address the pedagogical objectives of the pre-registration program through clinical practicum and meet their obligations to students. Employers on the other hand, have a say in shaping the skills sets of future graduates, and use clinical practicum as a recruitment mechanism.

It is also clear that the State and Territory Governments contribute to the costs of training health professionals through resource allocation and as a major employer group. For example, the Victorian Government provides funding to public hospitals to support clinical training for medical, nursing and allied health disciplines through the Waited Inlier Equivalent Separations (WIES) formula. This is in recognition of the addition cost burden borne by major teaching institutions.

In addition, some State and Territory Governments provide funding support directly to students. For example, NSW Health provides financial assistance to students through scholarships, including Aboriginal Undergraduate Scholarships, Undergraduate Metropolitan Placement Grants and Undergraduate Rural Placement Grants (similar grants are also available to allied health students). Similarly, through the Undergraduate Rural Clinical Placement Support program in Victoria (Department of Human Services) undergraduate students of nursing courses may be eligible for a grant of up to $100 per week (maximum $500) when undertaking rural clinical placements in a Victorian public health service a significant distance from their place of residence.

[16] Each benchmark includes a rationale and good practice criteria. The authors suggest that the benchmarks may be used as the basis for internal university auditing of quality teaching and learning in nurse education (Clare et al. 2003).

HSPs contend there is a net cost to the health services of providing the clinical placements (Victorian Government 2005) and that with new models of clinical practicum, which rely on greater participation by service staff, these costs are escalating. Health services also experience increases in consumables and a slow-down effect (slowed patient throughput) with student teaching, (Victorian Government 2005). There is a view that with increased HSP responsibility for clinical supervision, the costs for universities are offset. However, many universities report that savings of this nature are taken up by additional administrative costs particularly with respect to maintaining the collaborative partnership.

Increasingly, health services are entering into financial and/or service arrangements with HEPs whereby a value or charge is applied to clinical placements. For example, HEPs seeking clinical placements in Queensland Health services are required to enter into a Clinical Deed which formalises the responsibilities of both HEP and HSP. The Deed in 2006 stipulates that $30.07 will be charged per student clinical placement hour for clinical facilitators and preceptors. It is noted that many private HSPs are adopting similar policies with respect to charging universities to offset costs to their organisations. This type of arrangement has significant impact on the cost of providing clinical practicum for HEPs and arguably reduces flexibility and erodes opportunities for HEP to introduce collaborative arrangements.

Appropriate funding for clinical practicum is therefore contingent of identifying the real costs of providing the clinical component of the nursing program and apportioning those costs. A number of attempts have been made to assess (or develop models to assess) the full costs of health education, including the academic and clinical practicum requirements, and to determine responsibility for funding components (Victorian Government 2005). These exercises have noted that disaggregating the costs may results in arbitrary and meaningless "cost-bucketing" and lead to unintended consequences. Currently, there is no agreed working model or methodology that accounts for the various clinical practicum costs or the benefits to the various stakeholders.

It is clear in the Australian setting that the operational cost of clinical practicum in pre-registration nursing programs varies across HEPs and with the model of clinical practicum in place. Supervision and clinical support costs are flagged as the major component. However, distance or location of the practice setting also has implications for overall cost.

Given that nursing education and clinical practicum are conducted in so many public and private institutions, by a wide range of large and small HEPs in both metropolitan and rural locations, and that clinical practicum for nurses occurs in a wide range of clinical services and settings, one approach or model of clinical practicum is unlikely to be practical or feasible. Therefore, any methodology developed for determining and apportioning the costs needs to take into account the following:

- Costs for HEPs might include salaries for full-time and part-time faculty and clinical teaching staff, administration and coordination, ongoing liaison and supports for clinical staff and preception, programs for professional development of clinical agency staff, development of learning, assessment and evaluation tools and quality improvement activities. It should be noted that there is a sizable gap between award/EBA pay rates for faculty-based clinical teachers and clinicians employed as clinical teachers or facilitators.
- Costs for clinical agencies arise from changes to staffing due to reduced productivity; providing teaching and learning supports and resources for both students and preceptors; managing the risks associated with students in the clinical environment; increased consumables and decreased patient throughput in the learning environment; reimbursement or reward for preceptors.

- Costs for students might include parking, transportation, uniforms, time spent travelling, or missed opportunity costs through inability to secure part-time employment.
- Costs for preceptors might include their additional need for orientation and professional development, ongoing support and the burden of additional responsibility.
- Costs for patients and clients may derive from risks associated with different models of clinical learning and supervision and their impact on the overall quality of care and service delivery, as well as delayed patient throughput in a teaching/learning environment.

This type of costing exercise should also take into account the benefits for the various parties, and consider how benefits should be offset against costs, eg. how the unpaid work of the student contributes to productivity and patient throughput.

4.5. New approaches to clinical learning

In a changing context there is opportunity to consider whether there are new and different ways of approaching the development of clinical competence for licensing.

Simulation labs

Nationally and internationally, advances in health and education technology are contributing to greater use of simulation technology in health professional education (Issenberg, McGaghie et al. 1999; Epstein and Hundert 2002).

Simulation-based teaching methods, in conjunction with theoretical teaching and clinical experience, can play an important role in the training of safe and competent health professionals. Simulation learning allows trainees to reach a level of competence and safety before working with patients. In this environment, students can make mistakes without adverse consequences to patients (Department of Human Services (Victoria)).

However, substantial investment is required to establish high-tech facilities, making them an expensive resource if charges based on a cost recovery are levied. On the other hand, utilization costs may be offset by decreases in costs for clinical practicum in health service settings. Low-tech simulation learning may also be used to good effect for the development of a variety of skills sets required for different professional groups in a range of health settings and may be a cost-effective solution to developing competence in less technical or complex skills sets.

In a context of competition for limited clinical learning resources, simulation facilities can play a significant role in skill acquisition and maintenance for health professionals and will add a new dimension to interdisciplinary or team learning. However, at present some regulatory authorities do not provide flexibility in the standards for courses to allow for the utilization or exploration of these approaches to clinical learning.

The integration of simulation learning in nursing programs at present is seen as complementary to clinical practicum. The full potential of this form of learning has not been fully explored. To do this greater flexibility in the framework of standards applied to programs leading to registration is required along with rigorous research to evaluate the impact and outcomes of simulated learning on the development of professional competence, work readiness, patient safety and the costs of professional health education.

Interdisciplinary learning (IDL)

There is international interest in interprofessional or interdisciplinary learning (IPL/IDL) for health professionals. The literature strongly suggests that IDL can lead to collaborative practice, and collaborative practice provides service efficiencies and better outcomes for patients/clients (Braithwaite and Travaglia 2005) Canada, for example, is investing substantial funding in the development and evaluation of educational programs that promote collaborative patient-centred practice. Health Canada's policy position is that changing the way health providers are educated is key to achieving system change and to ensuring that health providers have the necessary knowledge and training to work effectively in interprofessional teams within the evolving health care system[17]. The UK has similarly taken up the challenge of IDL with many universities undertaking research in the field, and promoting the IDL components of courses as a marketing feature.

Currently, there are no fully-integrated IDL programs leading to health professional registration on offer, and there is limited local experience to draw on. While it can be said that there is general support for the concept of interprofessional education, uptake is hampered by a lack of systematic evidence of its effectiveness or direct effect on competence attainment, care of patients and organisational outcomes. Similarly, the impact on utilization of clinical learning resources (clinical placements, etc.) and costs arising from clinical practicum for education and HSPs have not been explored.

IDL presents a number of challenges for the Australian system of health professional education and regulation, which is historically separated by discipline, including:

- Commitment is required by all participating health professions and their regulatory authorities to work together to implement change; this will involve overcoming resistance from groups seeking to preserve the integrity of the disciplines.
- There is limited high-level evidence to support the substantial financial commitment required to develop and implement IDL models.
- IDL programs and curricula must meet the course accreditation requirements of all the health professional regulatory authorities involved[18], so there will be complex consultative processes involved.
- Some health professional courses are offered in isolation (eg. nursing programs may be the only health professional programs offered by the HEP or at a particular campus), and there is a proportionally greater number of nurses, in contrast to students in other disciplines, in which case IDL models would need to be facilitated through inter-institutional collaboration.
- Developing the capability of academics to teach in interdisciplinary models will take time and further investment.
- Health services will also need to collaborate in the provision of interdisciplinary clinical practicum programs that meet the competency requirements for professional registration for each of the collaborating disciplines.

As international experience with IDL grows, we will be more able to gauge the impact and application of IDL in the Australian context, and to ascertain whether there are cost efficiencies and tangible professional/practice benefits to be gained from investing in integrated approaches to training health professional teams.

[17] Health Canada – http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html

[18] The Productivity Commission has proposed a National Accreditation Agency, which will bring uniformity to the standards applied to health professional courses leading to registration.

Clinical placement opportunities

At present, clinical practicum in pre-registration nursing programs is undertaken in a range of clinical settings. However, the clinical component is traditionally weighted towards nursing in acute and subacute hospital settings, and experience suggests that community experience is not necessarily valued by employers who want new graduates in tertiary hospitals to be work ready. In part, this is because it is administratively easier and more cost efficient to negotiate the volume of clinical placements with larger health service organisations. Students are therefore exposed to limited nursing practice roles.

Nursing is continually expanding its practice boundaries and increasingly nurses are taking on new and different roles in community and other settings. With pressure on clinical placements, non-traditional nursing roles also provide opportunities for students to practice and develop skills in service settings where they are likely to work in the future, eg. in community services and clinics, general practice clinics, school nursing and health promotion activities.

Clinical practicum in these situations presents new challenges, particularly in dealing with issues of client confidentiality. However, other allied health professions have developed models which utilise opportunities to work with private practitioners and have learned to negotiate client sensitivities in the process.

Exploring new clinical practicum placements is also an opportunity to evaluate which clinical practicum settings are better suited to developing competence in the different professional competency domains, so that scarce clinical learning resources can be utilised more effectively. For example, aged care services provide different sorts of opportunities, as do mental health services and community services.

4.6. Section summary

- Nursing and midwifery regulatory authorities set the standards and minimum requirements for programs leading to licensing, including the standards for clinical practicum. However, there are currently inconsistencies in these standards across Australia.
- Similar to other health professions, there is a paucity of contemporary evidence to support the minimum standards required by regulatory authorities for nursing courses; standards have developed through experience and mostly reflect custom and practice.
- Minimum standards and requirements for clinical practice have implications for the baseline costs of programs, and thus merit further examination.
- Escalation in costs is associated with a number of factors arising from the model of clinical practicum and are linked to program improvements which are aimed at strengthening relationships between health services and education providers for better student outcomes, increases in clinical practicum hours, supervision arrangements and charges levied by health services.
- Higher education providers, health service providers and clinicians, students and patients all share the costs. However, currently there are no agreed methodologies for disaggregating and apportioning the costs.

5. Conclusion

The survey undertaken by the Taskforce into utilisation of additional clinical practicum funding highlights that HEPs have welcomed additional Commonwealth funding to support clinical practicum, but have viewed this increment as going only part way towards meeting the actual costs of providing nursing programs that meet the regulatory standards required for licensing and the expectation of employers and HSPs.

A number of pressures have been identified as contributing to the spiralling costs of clinical practicum, including minimum regulatory requirements for clinical practicum, administrative costs associated with increased numbers of students, clinical hours and charges by health services and supervision or partnership arrangements including liaison, consultation and supervision arrangements. It is evident that while many of the program improvements implemented by universities are to align programs with the best practice benchmarks for clinical practicum identified in the AUTC report, they also contribute to substantial cost increases.

The strong view from universities is that DEST funding arrangements for nursing have been based on historical understandings of the components of nursing programs and are not keeping pace with the realities of educating nurses and midwives for licensing and contemporary practice. Education providers have up until now accommodated the costs of program improvements and changes through internal cross-discipline subsidisation. However, it is evident that the costs associated with nursing programs, and particularly clinical practicum, are now escalating to the point where the sustainability of nursing programs is a serious concern for HEPs. Additional funding by the Australian Government for clinical practicum is in recognition that existing funding arrangements are inadequate in the current context. Hence, there is a strong argument for DEST to review the baseline funding arrangements and policy to ensure HEPs can continue to provide quality programs that ensure graduates meet the requirements of contemporary practice in a complex and changing health environment.

There would be benefit in the policy review process in unpacking the main cost drivers flagged in this report, to develop a better understanding of their complex interplay and the likely sequelae of allowing any one agenda (eg. the work readiness agenda) to dominate the construction of nursing education at this point in time. In this context, consideration should be given to the following:

- There is currently variation in the standards for courses leading to licensing across Australia. The ANMC project in process to develop agreed standards for accrediting courses leading to licensing is likely to provide a more uniform approach to minimum requirements for clinical practicum. The evidence to support minimum requirements is being reviewed in the context of this work.

  A national policy direction arising from the Productivity Commission report (2006) to implement a system of national registration and a mechanism for national accreditation of courses leading to licensing of health practitioners, will have a significant impact on standardising clinical practicum requirements. A national system of accreditation will bring elements of uniformity to standards for all health professions as well as uniformity for each discipline, but should also provide sufficient flexibility to allow for program diversity catering to the clinical practicum needs of nursing students across Australia.

  It is evident from the literature that there is insufficient robust evidence to support any one approach to clinical practicum or appropriate staffing and supervision arrangements. There is also little evidence to indicate whether different approaches may be better suited to achieving competence in different service settings and sectors. Consequently, there are challenges in definitively prescribing minimum requirements that might provide a baseline for calculating funding.

Clearly, research into the impact and outcomes on competence and cost of new and different approaches to clinical competence is required (eg. simulation learning), and as a body of knowledge is built, greater clarity with respect to best practice models will emerge. In the meantime, a flexible regulatory framework is needed to promote innovative approaches to clinical learning and competence attainment that are pedagogically sound, provide for safe practice and are cost effective.

- This survey indicates that at present, most nursing programs exceed minimum clinical hours requirements where prescribed by RAs. This phenomena merits close scrutiny as clinical hours are a major cost driver. The AUTC best practice benchmarks promote strengthened relationships, and responsiveness and collaboration in customising programs is a key element of this type of educational partnership. The N³ET survey shows that education providers have in some cases responded to the needs of HSPs for more work-ready graduates by increasing clinical hours. This is a direct driver of cost, and also a driver of the competitive clinical placement market.

  The tension between what is needed to achieve competency requirements for licensing and what is required for work readiness needs to be addressed, particularly when a number of HEPs with small nursing programs have identified that their students are disadvantaged when suitable clinical placements cannot be sourced or negotiated. This problem is exacerbated when programs increase practicum hours and in turn increase demand on clinical placements.

  Given that the Australian Government provides funding for Commonwealth-supported nursing places, there is a reasonable expectation that all students will have access to programs of equitable quality, where the likelihood of success is enhanced by access to suitable clinical placements. Consolidating nursing into fewer but larger nursing schools, may address the brokerage of clinical placements, but at the same time may decrease access to training for some students.

  As nursing is a NPA and the largest professional group in the health workforce (with a substantial projected workforce deficit), it would be reasonable for educational policy to continue to promote nursing offerings across Australia and to formulate policy and funding arrangements that assist smaller and newer providers to build the capacity of their nursing programs without disadvantage.

- The N³ET survey shows that clinical placements are a commodity in demand, and that there is increasing pressure on supply. There is also instability in the clinical environment, making clinical arrangements difficult.

  In the first instance, greater regulatory flexibility with respect to restrictions placed on clinical practicum (night duty and weekend placements) will allow for better utilisation of existing resources.

  There is also merit in exploring whether a centralised agency or strategy for allocating clinical placements (at the state level) might alleviate some of the administrative burden associated with clinical practicum and ensure equity of access for students. However, this approach would need to be mindful that currently HEPs enter into arrangements with both public and private providers for clinical placements, and these arrangements include financial or reciprocal arrangements, whereby HSPs are compensated for the time, resources and clinical expertise devoted to educating students on clinical practicum.

A centralised approach will have its own challenges. For example, while it might be possible to quantify the clinical practicum hours required on an annual basis for all students, this will be a difficult exercise given that students from different universities have different requirements (amount and timing). The logistic difficulty is further compounded by a lack of understanding of clinical placement capacity within the system. It is likely that placement capacity is linked to both the client population and staffing models, so that clinical areas such as residential aged care, where there is a low proportion of registered nurses might have less capacity than higher acuity areas. Likewise, in community settings, supervision capacity may be limited by the nature of the work. Thus, a prescriptive approach may be of limited use.

The issue of charges or levies by HSP is thus a complicated one and is tied up with the bigger issue of who should pay for training the next generation of health professionals. With the commodification of health, there is increasing emphasis on the cost effectiveness of health services and decreasing emphasis on preparing and supporting health professionals in training. This is not core business as it once was, yet health services benefit from and therefore have an interest in having a workforce that is adequately prepared for professional practice.

It is fair to assume, that costs associated with increased clinical practicum might be partially offset by decreased time on campus (lectures and tutorials). There is also a strong argument for recompensing HSP for the resources devoted to student learning, which would otherwise have been born by the HEP. It is evident that depending on the partnership and the program design, that different financial arrangements have been negotiated and often include elements of in-kind support.

In announcing additional funding for clinical practicum (April 8), State and Territory Governments have been encouraged to match the Commonwealth's contribution by guaranteeing clinical placements for all students in Commonwealth-supported higher education places. This might be as simple as waiving levies for clinical placements in public health services, or might include a government contribution to administrative costs through funding a central placement agency.

Diverting funding to health services in recognition of the costs of clinical practicum at this point is not justifiable without a clear and agreed methodology for accounting for and apportioning the costs and benefits of clinical practicum. Any methodology devised for this purpose would need to account for a range of cost drivers and also allow for a variety in approaches to achieving clinical competence suited to specifics of different programs.

The guiding principles of the NHWSF include that "Cohesive action is required among the health, education, VET[19] and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, (and) engaged in life-long learning…". The direction from COAG supports and endorses the NHWSF and supports the organisation of clinical education and training, and accreditation of courses for registration.

In this case, educational programs preparing nurses for licensing need to be responsive to the changing needs of the health service sector. At the same time, there needs to be a balance between government, HSP/employer and professional/regulatory interests. This clearly requires a cohesive approach that involves DEST funding policy, regulatory consistency, State/Territory Government contributions and moderation of employer expectations, and a strategic vehicle to engage the stakeholders, manage competing interests and evaluate the impact and outcomes of new approaches to clinical practicum.

[19] VET – Vocational Education and Training (VET)

Summary

The survey undertaken by the Taskforce shows that all universities providing Bachelor of Nursing programs leading to registration received additional Commonwealth funding to support student clinical practicum and utilised these funds in different ways. Even though the amount has been indexed annually since introduction, and there is now a commitment to further increase this funding component, universities have serious concerns about the financial viability and sustainability of nursing programs in the future. The costs of programs are escalating, particularly the costs associated with clinical practicum and there is a strong view that DEST funding policy is not keeping abreast of the actual costs of providing programs that meet the requirements of regulatory authorities, students and HSPs.

As nursing is a National Priority Area in education for the Australian community, it is essential that additional funding to nursing programs is continued and forms a permanent part of the baseline funding for this discipline cluster so that the HES can continue to educate nurses in light of predicted demand.

A more detailed review of the baseline level of funding is merited to arrive at a sustainable funding level that balances the pedagogical needs of students with the regulatory requirements for licensing and the work readiness concerns of employers. Clearly, the needs of health consumers should also have a voice in this dialectic. In the complex interface between health and education, it is likely that funding policy will form one strand of a strategic approach to clinical practicum for undergraduate nurses. There would also be benefit in unpacking the complex and interrelated factors driving the spiralling costs of nursing programs.

6. Appendices

Appendix 1: DEST codes and funding clusters

Discipline groups contained in the Nursing Cluster (12).

060300 = "Nursing"

060301 = "General Nursing"

060303 = "Midwifery"

060305 = "Mental Health Nursing"

060307 = "Community Nursing"

060309 = "Critical Care Nursing"

060311 = "Aged Care Nursing"

060313 = "Palliative Care Nursing"

060315 = "Mothercraft Nursing and Family and Child Health Nursing"

060399 = "Nursing not elsewhere classified"

Appendix 2: Survey respondents

State/Institution

New South Wales

Australian Film, Television and Radio School
Avondale College
Charles Sturt University
Southern Cross University
The University of New England
The University of Newcastle
The University of Sydney
University of Technology, Sydney
University of Western Sydney
University of Wollongong

Victoria

Deakin University
La Trobe University
Melbourne College of Divinity
Monash University
Royal Melbourne Institute of Technology
Swinburne University of Technology
The University of Melbourne
University of Ballarat
Victoria University of Technology

Queensland

Bond University
Central Queensland University
Christian Heritage College
Griffith University
James Cook University
Queensland University of Technology
University of Southern Queensland

Western Australia

Curtin University of Technology
Edith Cowan University
Murdoch University
The University of Notre Dame Australia
The University of Western Australia

South Australia

The Flinders University of South Australia
University of South Australia

Tasmania

University of Tasmania

Northern Territory

Batchelor Institute of Indigenous Tertiary Education
Charles Darwin University

Australian Capital Territory

The Australian National University
University of Canberra

Multi-State

Australian Catholic University

Appendix 3: Funding to universities for nursing and clinical practicum 2005

	Nursing						
Institution	Total agreed number of places	Total funding rate	Practicum funding rate	Non-practicum funding rate	Total funding	Total practicum funding	Total non-practicum funding
Charles Sturt University	568	9,750	659	9,091	5,538,000	374,312	5,163,688
Southern Cross University	351	9,750	659	9,091	3,422,250	231,309	3,190,941
The University of New England	249	9,750	659	9,091	2,427,750	164,091	2,263,659
The University of Newcastle	710	9,750	659	9,091	6,922,500	467,890	6,454,610
The University of Sydney	400	9,750	659	9,091	3,900,000	263,600	3,636,400
University of Technology, Sydney	790	9,750	659	9,091	7,702,500	520,610	7,181,890
University of Western Sydney	1,215	9,750	659	9,091	11,846,250	800,685	11,045,565
University of Wollongong	376	9,750	659	9,091	3,666,000	247,784	3,418,216
Deakin University	836	9,750	659	9,091	8,151,000	550,924	7,600,076
La Trobe University	1,249	9,750	659	9,091	12,177,750	823,091	11,354,659
Monash University	718	9,750	659	9,091	7,000,500	473,162	6,527,338
Royal Melbourne Institute of Technology	584	9,750	659	9,091	5,694,000	384,856	5,309,144
University of Ballarat	423	9,750	659	9,091	4,124,250	278,757	3,845,493
The University of Melbourne	73	9,750	659	9,091	711,750	48,107	663,643
Victoria University of Technology	517	9,750	659	9,091	5,040,750	340,703	4,700,047
Central Queensland University	244	9,750	659	9,091	2,379,000	160,796	2,218,204
Griffith University	833	9,750	659	9,091	8,121,750	548,947	7,572,803
James Cook University	509	9,750	659	9,091	4,962,750	335,431	4,627,319
Queensland University of Technology	937	9,750	659	9,091	9,135,750	617,483	8,518,267
The University of Queensland	210	9,750	659	9,091	2,047,500	138,390	1,909,110
University of Southern Queensland	459	9,750	659	9,091	4,475,250	302,481	4,172,769
University of the Sunshine Coast	15	9,750	659	9,091	146,250	9,885	136,365
Curtin University of Technology	488	9,750	659	9,091	4,758,000	321,592	4,436,408
Edith Cowan University	903	9,750	659	9,091	8,804,250	595,077	8,209,173
Murdoch University	89	9,750	659	9,091	867,750	58,651	809,099
The Flinders University of South Australia	850	9,750	659	9,091	8,287,500	560,150	7,727,350
The University of Adelaide	12	9,750	659	9,091	117,000	7,908	109,092
University of South Australia	932	9,750	659	9,091	9,087,000	614,188	8,472,812
University of Tasmania	506	9,750	659	9,091	4,933,500	333,454	4,600,046
Batchelor Institute of Indigenous Tertiary Education (not surveyed)	1	9,750	659	9,091	9,750	659	9,091
Charles Darwin University	382	9,750	659	9,091	3,724,500	251,738	3,472,762
University of Canberra	199	9,750	659	9,091	1,940,250	131,141	1,809,109
Australian Catholic University	993	9,750	659	9,091	9,681,750	654,387	9,027,363
Sub-Total	**17,621**	**9,750**	**659**	**9,091**	**171,804,750**	**11,612,239**	**160,192,511**
Private Providers							
Avondale College	33	9,750	659	9,091	321,750	21,747	300,003
The University of Notre Dame Australia	91	9,750	659	9,091	887,250	59,969	827,281
Sub-Total	**124**	**9,750**	**659**	**9,091**	**1,209,000**	**81,716**	**1,127,284**
GRAND TOTAL	**17,745**			**18,182**	**173,013,750**	**11,693,955**	**161,319,795**

Appendix 4: Commonwealth resources to universities

A. Core Funding:	Commonwealth Grant Scheme (CGS) / Base Operating Grant Regional loading Enabling loading Workplace Reform Program National Institutes Over-enrolment funding Student contribution/HECS liabilities
B. Program Funding:	Transitional Fund Indigenous Support Funding Higher Education Equity Students with Disabilities Program Superannuation Grants Capitol Development Program Collaboration and Structural Reform Fund Indigenous Staff Scholarships Other Program funding
C. Research Funding:	Research Training Scheme Institutional Grants Scheme Research Infrastructure Block Grants Regional Protection Scheme ARC Grants NHMRC Grants Other Research Programs
D. Student Support Funding:	Australian Postgraduate Awards International P/G Research Scholarships (OPRS) Education Cost Scholarships Accommodation Scholarships
E. Non-University Programs	National Institute for Teaching & Learning Australian University Teaching Awards Quality Fund Indigenous Higher Education Advisory Council

Modified from the Commonwealth Resources and Student Contributions available to Higher Education Institutions 2000-2008, reproduced from the AVCC website.

Appendix 5: 2006 Commonwealth Supported Nursing Units of Study (EFTSL)

Provider	Undergraduate student load
Avondale College	41
Charles Sturt University	624
Macquarie University	0
Southern Cross University	437
University of New England	276
University of New South Wales	0
University of Newcastle	769
University of Sydney	191
University of Technology, Sydney	818
University of Western Sydney	1,149
University of Wollongong	391
Deakin University	839
La Trobe University	819
Monash University	695
Royal Melbourne Institute of Technology	550
Swinburne University of Technology	0
University of Ballarat	429
University of Melbourne	70
Victoria University of Technology	528
Central Queensland University	232
Christian Heritage College	0
Griffith University	859
James Cook University	543
Queensland University of Technology	886
University of Queensland	350
University of Southern Queensland	515
University of the Sunshine Coast	52
Curtin University of Technology	525
Edith Cowan University	915
Murdoch University	120
University of Notre Dame, Australia	187
University of Western Australia	0
Flinders University of South Australia	938
Tabor College	0
University of Adelaide	27
University of South Australia	937
Australian Maritime College	0
University of Tasmania	540
Batchelor Institute of Technology	1
Charles Darwin University	361
Australian National University	0
University of Canberra	226
Australian Catholic University	1,077
TOTAL	**17,914**

Data supplied by DEST.

Appendix 6: Higher Education Contribution charges for selected universities for nursing in 2006

	HECS cost per year	HECS per year above $3920	University Nursing course
Southern Cross Uni (Port Macquarie)	$5,026	$1,106	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=48839
University of New England	$4,695	$775	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=50988
University of Wollongong	$4,240	$320	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=51771
University of Technology – Sydney	$4,680	$760	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=58480
University of Newcastle (Ourimbah)	$4,787	$867	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=45690
University of Newcastle	$4,669	$749	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=47075
Charles Sturt University (Albury)	$5,364	$1,444	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=58458
Charles Sturt University (Bathurst)	$5,364	$1,444	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=58910
Uni of Western Sydney (Campbelltown)	$4,819	$899	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=59197
Uni of Western Sydney (Parramatta)	$4,819	$899	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=59096
JCU (Townsville)	$4,728	$808	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=43877
JCU (Cairns)	$4,728	$808	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=44494
CQU Rockhampton	$4,860	$940	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=45711
Griffith (Gold Coast)	$4,245	$325	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=52753
Queensland Uni of Technology (Kelvin Grove)	$5,154	$1,234	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=53899
Charles Darwin University	$4,852	$932	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=45061
University of South Australia	$5,113	$1,193	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=51235
La Trobe (Bendigo)	$4,923	$1,003	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=53590
La Trobe (Bundoora)	$4,307	$387	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=49879
ACU (Ballarat)	$4,684	$764	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=42664
Deakin (Burwood)	$5,005	$1,085	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=47990
Deakin (Warrnambool)	$5,005	$1,085	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=52312
RMIT (Bundoora)	$4,651	$731	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=52576
RMIT (Hamilton)	$4,668	$748	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=52919
ECU (Bunbury)	$4,717	$797	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=46964
Murdoch Uni (Mandurah)	$5,270	$1,350	http://www.goingtouni.gov.au/CourseDetails.htm?CourseId=43571

Appendix 7: Commonwealth contribution and student contributions for 2005 and 2006

Funding cluster	Commonwealth contribution amounts for 2005	Commonwealth contribution amounts for 2006
Law	$1,472	$1,499
Accounting, administration, economics, commerce	$2,420	$2,466
Humanities	$4,078	$4,156
Mathematics, statistics	$4,817	$4,908
Behavioural science, social studies	$6,475	$6,598
Computing, built environment, health	$7,212	$7,349
Foreign languages, visual and performing arts	$8,869	$9,037
Engineering, science, surveying	$12,003	$12,232
Dentistry, medicine, veterinary science	$15,047	$15,332
Agriculture	$15,996	$16,299
Education	$7,116	$7,251
Nursing	$9,511	$9,692

Going to Uni: Higher Education for students in Australia
http://www.goingtouni.gov.au/Main/FeesLoansAndScholarships/Undergraduate/CommonwealthSupportForYourPlaceAndHECS-HELP/WhatYouPay.htm#1

Appendix 8: Student contribution ranges

Student contribution ranges for new students commencing after 1 January 2005

The table below gives the ranges within which providers may set student contributions for units of study in 2005 and 2006 for new students commencing after 1 January 2005.

Student contribution band	Student contribution ranges for 2005, Post-2005 students	Student contribution ranges for 2006, Post-2005 students
Band 3 (law, dentistry, medicine, veterinary science)	$0 – $8,018	$0 – $8,170
Band 2 (accounting, administration, economics, commerce, mathematics, statistics, computing, built environment, health, engineering, science, surveying, agriculture)	$0 – $6,849	$0 – $6,979
Band 1 (humanities, behavioural science, social studies, foreign languages, visual and performing arts)	$0 – $4,808	$0 – $4,899
National priorities (education, **nursing**)	$0 – $3,847	$0 – $3,920

Student contribution ranges for 2005 and 2006 for students continuing with a course they began before January 2005

The table below gives the ranges within which providers may set student contributions for units of study in 2005 and 2006 for pre-2005 HECS students.

See also: Pre-2005 HECS students

Student contribution band	Student contribution ranges for 2005, Pre – 2005 HECS students	Student contribution ranges for 2006, Pre – 2005 HECS students
Band 3 (law, dentistry, medicine, veterinary science)	$0 – $6,414	$0 – $6,535
Band 2 (accounting, administration, economics, commerce, mathematics, statistics, computing, built environment, health, engineering, science, surveying, agriculture)	$0 – $5,479	$0 – $5,583
Band 1 (humanities, behavioural science, social studies, foreign languages, visual and performing arts)	$0 – $3,847	$0 – $3,920
National priorities (education, **nursing**)	$0 – $3,847	$0 – $3,920

Student contribution ranges for 2005 and 2006 for pre-1997 students

The ranges within which providers may set student contributions for students who began their course before 1 January 1997 (pre-1997 students) are $0 to $2,889 for units of study undertaken in 2005 and $0 to $2,943 for units of study undertaken in 2006.

See also: Pre-2005 HECS students

Appendix 9: Head of power for determining educational requirements for nurses and midwives

State/ Territory	Act / Regulations	Section No./ Reference	Section Text
ACT	*Health Professionals Regulation 2004 ACT*	3.4 [Act, s 22 (1) (a)]	Board responsible for assessing courses for nurses etc. (1) The Board is responsible for assessing courses for their suitability as educational and training courses for the registration and enrolment of nurses. (2) The courses included in this schedule have been assessed and approved by the Board.
NT	*Health Practitioners Act 2004 NT*	S10	Functions of Boards (1) A Board has the following functions: (a) to administer the scheme of registration and enrolment under Part 3 in relation to the category of health care practice for which it is established; (g) to accredit courses for entry into the category of health care practice for which it is established; (h) to accredit educational institutions to conduct courses referred to in paragraph (g);
NSW	*Nurses and Midwives Act No 9 1991 NSW*	S10	Functions of Board (1) The Board has the following functions: (g) for the purpose of facilitating under this Act the registration of nurses and midwives, the authorisation of registered nurses to practise as nurse practitioners, the authorisation of registered midwives to practise as midwife practitioners and the enrolment of enrolled nurses and enrolled nurses (mothercraft), to grant recognition to: (i) hospitals, nursing homes and educational and other institutions offering courses for the training of nurses, nurse practitioners, midwives, midwife practitioners and enrolled nurses and enrolled nurses (mothercraft), and (ii) the curricula for such courses, and (iii) diplomas, certificates and other qualifications awarded to persons who successfully complete those courses.
QLD	*Nursing Act 1992 Qld*	S7	Council's functions The functions of the Council are to— (h) determine examinations, qualifications, experience and other requirements to be fulfilled by persons applying for and maintaining registration, enrolment or authority to practise under this Act, and monitor standards of student assessment in schools of nursing.
SA	*Nurses Act 1999 SA*	S16	1) The functions of the Board are as follows: (c) to approve courses of education or training that provide qualifications for registration or enrolment as a nurse under this Act; (d) to determine the requirements necessary for registration or enrolment under this Act;
TAS			****Not yet determined****
VIC	*Nurses Act 1993 Vic*	S66	Powers, functions and consultation requirements (1) The Board has the following functions— (eb) to accredit courses of study or recognize clinical experience that provides competence for each category of nurse practitioner for which registration may be endorsed under section 8B.
WA *1992 WA*	*Nurses Act*	S23	Meaning of approved educational qualification (1) For the purposes of section 22(2)(d) or 22A(2)(b), a person holds an approved educational qualification if the person — (a) has gained a qualification approved by the Board, in relation to that section, granted by an Australian tertiary educational institution recognized by the Board; (b) in a country other than Australia, has completed a qualification in nursing approved by the Board, in relation to that section; or (c) is registered provisionally under section 26 and has completed a course of nursing training or study approved by the Board under subsection (1)(b) of that section in respect of that person.

Appendix 10: ANMC Competency Standards for Registered Nurses and Midwives

The ANMC Competency Standards for Registered Nurses and Midwives are available from the ANMC website **http://www.anmc.org.au/**. The standards provide details of the skills, knowledge and attitudes expected of registered nurses and midwives at entry to practise, ie. how the nurse or midwife is expected to practise and his/her capacity to practice. They are the minimum standards required by all who seek authorisation to practise as a nurse or midwife in Australia.

The competencies are organised in domains:

Midwifery Domains	**Registered Nurse Domains**
• Legal and professional practise • Midwifery knowledge and practise • Midwifery as primary health care • Reflective and ethical practice	• Professional practise • Critical thinking and analysis • Provision and coordination of care • Collaborative and therapeutic practise
For example: Legal and Professional Practise Competency 1: Functions in accordance with legislation and common law affecting midwifery practise. Element 1.1: Demonstrates and acts upon knowledge of legislation and common law pertinent to midwifery practise. Cues: – Practises midwifery within the requirements of legislation and common law; – Identifies and interprets laws in relation to midwifery practise, including the administration of drugs, negligence, consent, report writing, confidentiality and vicarious liability.	For example: Professional practise Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practise, functioning in accordance with legislation affecting nursing and health care and the protection of individual and group rights. 1. Practises in accordance with legislation affecting nursing practice and health care. 1.1 Complies with relevant legislation and common law: – Identifies legislation governing nursing practise; – Describes nursing practise within the requirements of common law; – Describes and adheres to legal requirements for medications; – Identifies legal implications of nursing interventions; – Actions demonstrate awareness of legal implications of nursing practise.

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