



Submission to

Review of Australian Higher Education

New South Wales Nurses' Association
4 August 2008

Introduction

The New South Wales Nurses' Association (NSWNA) is the industrial and professional body that represents over 51,000 nurses in New South Wales. The membership of the NSWNA comprises all those who perform nursing work, including assistants in nursing (who are unregulated), enrolled nurses and registered nurses at all levels including management and education. The members of the NSWNA are also members of the Australian Nursing Federation (ANF), a federally registered industrial organisation, and form the NSW Branch of the ANF.

NSWNA commends the Australian Government's decision to conduct a comprehensive review of Australian higher education and welcomes the opportunity to contribute to the processes of the review.

We agree that Australia's future national prosperity will be dependent on our capacity for innovation and adaptability in industry and society and that higher education with its twin functions of teaching and research should be establishing a new economic, social and environmental order for the nation. This will require a revolution in the quality of the outcomes of higher education enabled by a revolution in the quantity of our investment in human capital.

From our perspective higher education has further relevance; not only are better educated communities healthier communities, better workforce participants and more productive, higher education is responsible for the creation and promotion of a viable and productive health workforce enabled to improve health outcomes for the community.

Developing this sort of community requires a higher education system, which is characterised by quality, diversity and equity of access and appropriately meets the country's economic and social needs. These features, while relevant to all disciplines, are particularly significant for nursing. Our health system requires well educated nurses, both at undergraduate and post graduate level, from a diverse range of backgrounds able to meet the needs of a diverse range of individuals and communities.

Clearly the key interests of the NSWNA are to ensure the best possible working environments for nurses and midwives which enable them to deliver quality care, achieve professional enrichment and make valuable contributions to the development of their professions. The capacity to achieve these goals is underpinned by appropriate educational preparation.

This submission will therefore focus on addressing questions regarding higher education which affect the ability of nurses and midwives to realise these goals.

Higher education in modern Australia

1. How adequate is the statement of functions and characteristics of higher education in modern Australia?

The statement of functions and characteristics generally captures these elements of higher education in modern Australia well, most particularly the statement of characteristics.

The statement of functions should be expanded to acknowledge and promote the responsibility of higher education institutions in leading public discourse. The contributions of university faculty to public discourse through the dissemination and popularisation (that is, making it accessible to the wider community) of research and intellectual participation in public debates have been significantly compromised over the last decade.

The restrictions imposed by the previous Australian Government's policies and attitudes to higher education have systematically eroded the capacity of higher education institutions and their academics to drive critical civil discourses; while the benefits that may have been brought to our society had these activities occurred have been lost.

It is time to reinvigorate higher education and reinstitute academic freedom and independent analysis so that the full range of universities' contributions to society is restored.

Meeting labour market and industry needs

2. Are there impediments to the higher education sector being able to innovate in the development of courses and programs? What are these impediments and how could they be removed?

A number of factors, which currently impede the capacity of the professions of nursing and midwifery for innovation in practice and education, could be rendered less influential through effective government policy and support.

The practice of nursing and midwifery and the subsequent provision of safe, quality care must be founded on sound, reliable evidence supported by research in the Australian context. However, there is a significant lack of nursing and midwifery research currently being undertaken in Australia relative to the need for this research.¹

While Australian nursing and midwifery research is growing, particularly clinical research, the body of knowledge on the practice of nurses and midwives, the nursing and midwifery workforce and its contribution to the functioning of the health system remains limited.

¹ Heath, P. (Chair) 2002, *National Review of Nursing Education. Our Duty of Care*, Commonwealth of Australia, Canberra

International research, although clearly useful, has limited applicability in the Australian context.

The size of the nursing and midwifery workforce, the cost of providing nursing and midwifery care and the overwhelming significance of this care to the health of our nation ought to warrant significant investment in the professions' research and development. However, this has not been forthcoming.

The current structural arrangements and competitive funding environments surrounding research are not favourable to disciplines such as nursing and midwifery. The contribution of the professions' research to health care, while critical, is not highly visible; consequently, potentially useful research has limited success in attracting funding and sponsorship from either traditional, e.g. the higher education sector and structures such as the NHMRC, or other sources, e.g. business or industry investment.

Not only does this impede the ability of nursing and midwifery to develop and implement innovative practices to improve care and outcomes but the lack of meaningful data on nursing and midwifery practice inhibits the creation and development of appropriate health policy and planning for a viable workforce.

Significant development of this country's nursing and midwifery research is therefore required, responsibility for which will rest with the higher education sector.

This will need investment from the Australian Government dedicated to the provision of nursing and midwifery research grants and the expansion of cooperative research centres for nursing and midwifery, with priority given to building the professions' research capacity and integrating research findings into practice. Development of the research capacity of the professions will necessarily include increases in the level of postgraduate research scholarships and research training places for nurses and midwives.

Another significant impediment to innovation in nursing and midwifery practice and education is entrenched opposition to health reform and associated necessary workforce redesign. Perpetuation of the illness/medical model of the Australian health system, archaic legislative frameworks and appeasement of anachronistic sectoral interests continue to prevent reform of the health system needed in this country.

This is not to suggest that substantial deconstruction of the regulatory arrangements for the health workforce or the health system is required. The first duty of the health system is the protection of public safety; this cannot be achieved without suitable regulatory arrangements. The NSWNA does not consider that regulatory control unnecessarily restricts workforce flexibility, corrodes diversity or inhibits innovation. Rather, regulation, which ensures a minimum standard of health care delivery and guarantees both the protection of the public and safe working environments for health professionals, is the only mechanism which can ensure protection of the public.

However, legislative frameworks for both practice and education of health professionals need to be dynamic and evolving so that they not only keep pace with the rapid development of health care but allow Australian practice and research to become pace setters in the global health care market. Regulatory arrangements which preserve outdated practices and work systems and unnecessarily inhibit development need to be addressed.

Clearly, implementing this level of change will not be simple; it requires time, reallocation of resources, community engagement and, most significantly, political will and commitment. However, it is necessary not only for the industry of higher education but for the health of the nation.

If impediments to innovation are to be removed, reorganising the way health care is delivered in this country by adopting a wellness/primary health care model focused on primary health care will be required. This will necessitate, as recognised by the Australian Government, a whole-of-government approach to health care delivery; health policy, which includes determining the best models of educational preparation for health professionals, cannot be effective if developed independently from social policy.

Within such an improved framework of health care delivery, effective and appropriate workforce redesign and other innovations will be achieved more readily.

The need for specialisation in the health professions will continue to exist and will most likely increase, and will need to be accommodated by appropriate education. However, the compartmentalised structure of the health workforce needs to be dismantled to promote the development of cooperative teamwork across traditional boundaries and prepare a more effective workforce better able to meet the community's future health care needs.

This must be addressed in the education of all health professionals. Many commentators argue for interprofessional learning for health professionals and highlight the need for generic health qualifications to prepare generalist health workers². These concepts are not new; at times nursing students have shared much of the early years of their education with allied health students. However, although many have been amenable to this concept it appears not to have been widely adopted by the higher education system.

The generalist health worker or health professional who acts as a point of central coordination in the delivery of care to patients adopts a useful and necessary role. Currently, and appropriately, nurses fill this role. Nurses have always been responsible for coordination of services for patients, a feature of health care delivery which is unlikely to change. They assume the roles and responsibilities of the nine-to-five health workers, providing elements of physiotherapy, occupational therapy and other professionals' practice within the normal delivery of nursing practice and frequently serve as the only constant for patients in what is often a bewildering experience.

² Duckett, S.J., 2005, Health workforce design for the 21st century, *Australian Health Review*, May, Vol 29, No 2.

We therefore suggest that rather than 'reinvent the wheel' in this regard, this generalist role of nurses should be maintained and, where appropriate, expanded. The propositions of this nature made by Stephen Duckett in his examination of health workforce redesign³, which include suggestions for reform of the education of health professionals, should be explored.

It is clear that a re-examination of the educational needs for health workers and health professionals is needed. The pivotal point however, is that any consideration of the appropriate education for workers within the health system must not be conducted separately from other health service planning and organisation. Therefore, design and development of education programs must be intrinsically linked with health and social policy and planning.

3. What are the appropriate mechanisms at the national and local level for ensuring higher education meets national and local needs for high level skills? What is the role of state and territory governments in this area? 4. How adequate are the mechanisms for aligning supply and demand of graduates?

The demand for high level nursing skills is high; there is currently a critical nursing shortage in Australia. The consequences of not addressing this problem now will be significant. Predictions estimate that NSW alone could face a shortage of 12,000 nurses by 2010, in the context of a national shortfall of 40,000 nurses, if nothing is done.

It is well understood that this will intensify as the population ages and the demand on health services increases. While Australia's health is generally good and our longevity is increasing, the amount of time we will spend living with disability and chronic illness is increasing and is greater than ever before increasing the need for care.

No government would disagree that this shortage exists. What is disagreed is the extent of shortage and who is responsible for fixing it.

Simply stated, the shortage is the result of supply not meeting demand, with supply affected by the numbers of new nurses being trained and the attrition rate of nurses from the workforce. However, the precise extent of the nursing shortage is difficult to quantify. Estimations vary significantly, reflecting the parlous state of health workforce planning in this country, and many do not include recent improvements in the supply of nurses from increases in training numbers.

A recent report commissioned by the Council of Deans of Nursing and Midwifery (Australia and New Zealand), *Nurse workforce futures*, indicates that recent and continuing increases in training numbers for registered nurses will ameliorate the shortage with the current annual shortfall of 3,243 new graduate nurses across Australia projected to reduce to 470

³ Duckett, S.J., 2005, Health workforce design for the 21st century, *Australian Health Review*, May, Vol 29, No 2.

by 2010⁴. The report points out though that this predicted improvement is based on current staffing levels which are insufficient. When predictions are based on staffing levels which are adjusted to be adequate, that is, with vacancies in the nursing workforce filled, the projected national shortfall for 2010 is 7,900 (3.6% of the RN workforce).

The previous federal and current state governments both implemented measures to increase training places for nurses in NSW. The NSW Health Department increased the number of enrolled nurses being educated from 900 to 1,200 in 2006 with a 21% increase in the number of enrolled and trainee nurses employed since 2001-2002⁵. The previous federal government increased the number of commonwealth supported positions (CSPs) in undergraduate nursing courses in 2005 - 2006 with a further 1,036 CSPs allocated for 2007 Australia-wide.

As it would appear that this is the most straightforward mechanism to be used at the national level for ensuring the need for nursing and midwifery skills are met, the current Australian Government has committed to continuing these increases.

However, assumptions that increasing training intakes, most particularly training places for registered nurses, will satisfactorily remedy the nursing shortage need to be approached with caution. It is somewhat simplistic to assume that if the numbers of places for nurse training are increased the number of nurses in the workforce will be increased.

This assumption does not allow for the complexities that are involved in the delivery of registered nurse education. The previous government allocated 326 new pre-registration nursing places (CSPs) to NSW for commencement in 2007⁶. However, though there was no shortage of applicants, not all places were offered by universities as they would only offer places in situations where they could ensure a quality education for all students.

The increase in nursing places was not accompanied by an increase in appropriately qualified academic and clinical staff to accommodate the increase in student numbers. Nor was it accompanied by increased access to clinical places for students. Clinical placements, an essential feature of nurse education to make the link between theory and bedside practice, are increasingly difficult to access and to fund. Although the previous federal government increased the funding for the clinical education component of nursing it remains insufficient.

The imbalances in funding for university education need to be understood as they place increased pressure on academics thereby compromising the quality of the education delivered and on students and new graduates as the burden of the increased costs of their

⁴ Preston, B. (2006) *Nurse workforce futures: development and application of a model of demand and supply of graduates of Australian and New Zealand pre-registration nursing and midwifery courses to 2010*, Council of Deans of Nursing and Midwifery (Australia and New Zealand), available online at: <http://www.cdnm.edu.au>

⁵ Ibid

⁶ Preston, B. (2006) *Nurse workforce futures: development and application of a model of demand and supply of graduates of Australian and New Zealand pre-registration nursing and midwifery courses to 2010*, Council of Deans of Nursing and Midwifery (Australia and New Zealand), available online at: <http://www.cdnm.edu.au>

education impacts on their working lives. (Funding issues are discussed in detail later in this submission)

For the strategy of increasing intakes in nurse education courses to genuinely contribute to reducing the nursing shortage, these issues need to be addressed in cooperation with state and territory governments so that the quality of nurse education is not compromised and that new graduate nurses and midwives are not encumbered by onerous debt and responsibility.

Also, decisions for allocations of nursing education places must be determined in accordance with sound workforce planning, which is informed by and developed from reliable, meaningful data and assessment. As discussed above, quality health workforce data has not been readily available in this country, which has led to poor planning decisions, subsequent over and under allocation of education places, resulting in workforce shortages.

The current paucity of meaningful nursing and midwifery (and health) workforce data is influenced by several factors including the division of responsibilities between state and federal governments for health and education and the dislocation of service delivery points from central planning units. Data may be further compromised as was discovered in NSW through research commissioned by the Independent Pricing and Regulatory Tribunal, which indicated that information gathering by hospitals tends to be reactive and responsive to financial imperatives and Area, Departmental and Ministerial requests rather than to drive change or plan for workplace or service improvements⁷.

Improvements are being made in the collection and utilisation of meaningful workforce data (for example in NSW, via the establishment of a single workforce planning unit) but much more needs to be done.

Primary responsibility for determining, allocating and funding training numbers for nursing and midwifery should not rest with state and territory governments. This is to ensure that national skills needs and appropriate professional and health care requirements, rather than local service needs, are met.

Of course, local service needs are important and must be addressed but regional governments and authorities will always be tempted to allow service needs and requirements to override educational and professional standards.

Meeting the demand for nursing and midwifery skills in all jurisdictions of Australia requires much better workforce planning undertaken through consultative arrangements between the Australian and state and territory governments.

⁷ Independent Pricing and Regulatory Tribunal of NSW, August 2003, *NSW Health Focusing on Patient Care*, Sydney.

Opportunities to participate in higher education

Applications for university courses have declined.^{8,9} The key reason for this is that students are unable to meet increased costs of living while at university. This is currently a greater deterrent than the accumulation of a HECS debt.^{10,11} This is most significant for potential students from socially and economically disadvantaged backgrounds, frequently from rural and regional communities. With no financial support available, these students are unable to participate in higher education despite their academic abilities.

The previous Australian Government made some efforts in assisting those from rural communities by the provision of a regional loading to universities and to limited numbers of scholarships for rural students. However, much more needs to be done in the provision of individual student income support. The Australian Government must review the income and other supports available for students so that all people have an equal opportunity to participate in higher education based on their capacity to succeed not their capacity to pay.

Currently 41% of all pre-registration nursing and midwifery commencements are at rural and regional campuses and the proportion of indigenous students enrolled in courses for initial registration as a nurse or midwife has increased over the last six years (from 1.2% - 1.8% of domestic students).¹² While these figures reward the efforts made by the professions of nursing and midwifery to increase the inclusiveness of the professions, more effort needs to be made. Nursing and midwifery remain largely mono-cultural and therefore unrepresentative of the society in which they operate.

National structures which encourage participation from all sectors of society, particularly those currently under-represented in higher education must be implemented. Clearly, this will necessary involve increased provision of financial and other supports to assist capable students from less advantaged sections of society to succeed in higher education.

It should also involve implementation of a wider range of pathways into the professions and better preparation and support for graduates as new professionals in the workplace.

⁸ Birrell, B. & Rapson, V., (2006), *Clearing the myths away: Higher education's place in meeting workforce demands*, Dusseldorp Skills Forum, available online at: <http://www.dsf.org.au>

⁹ Universities Australia, (2008), *Report on applications, offers and acceptances of undergraduate university places*, available online at: <http://www.universitiesaustralia.edu.au/documents/publications/stats/unmet/Report-on-undergraduate-demand-2008.pdf>

¹⁰ Birrell & Rapson, Op cit.

¹¹ Group of Eight, (2006), *2007-2008 Pre-budget submission*, available online at: <http://www.go8.edu.au/policy/papers/2006/Go8%20pre-budget%20submission%2024.11.06.pdf>

¹² Council of Deans of Nursing & Midwifery, (2007), *Pre-registration nurse education data collection & publication project 2007*, Available online at: <http://www.cdnm.edu.au/pdfs/DOHARepor080303.pdf>

The student experience of higher education

12. Is there evidence that declining student: staff ratios have impacted on the quality of the student experience?

Although universities aim to provide a quality education which ensures that all students are appropriately prepared for entry to nursing and midwifery practice, financial and other pressures imposed by the policies of the previous Australian Government have rendered this goal increasingly elusive.

These pressures are frequently misunderstood. It is often suggested by members of the community and occasionally by nurses themselves that current undergraduate programs are too short and do not produce clinically competent graduates. There is in fact no reliable evidence which supports this proposition. There is however, a volume of robust research which indicates that the key feature of clinical learning for nursing students is not its length but its quality.

The key issue for the nursing profession is to ensure that the factors which contribute to creating a quality clinical learning experience for students are provided so that the time students spend on placement is used to greatest advantage. These factors are the development of quality relationships and continued good communication between universities and health facilities; sufficient pre-clinical preparation of students; and, appropriate support from clinicians. All of these factors require the provision of proper resources and appropriate policy support from government.

Many of our 1,941 associate members (i.e. student members) report that these resources are simply not available. They have explained to us that consequently, they have difficulties in accessing academics and appropriate clinical learning time and facilities. They feel forced to compete with classmates for scarce resources and believe that their capacity to attain a quality education is impeded.

These frustrations then leave new graduates feeling uncertain and unsupported as they attempt to make the transition to the workplace. Many feel unable to make the transition successfully and leave the workforce thereby exacerbating the existing shortage.

This is not unique to nursing; Universities Australia¹³ reports that many professions believe their new graduates are lacking 'work-readiness' and have recommended implementation of national structures to increase work and employability skills of new professionals and facilitate their transition to work.

While we support implementation of programs and strategies which facilitate the transition for university graduates to the workplace, we must emphasise that what is most

¹³ Universities Australia, (2008), *A national internship scheme, enhancing the skills and work-readiness of Australian university graduates*, Available online at: <http://www.universitiesaustralia.edu.au/documents/publications/discussion/National-Internship-scheme-May08.pdf>

acutely needed for the successful transition of new nurses and midwives to the workplace is the provision of sufficient resources as outlined above.

13. How can the quality of learning outcomes in Australian higher education be measured more effectively?

The professions of nursing and midwifery have established national standards for practice as a nurse or midwife, which serve as benchmarks to assess performance and competence for entry to practice and for nurses and midwives to retain their licences to practise in Australia. This process is coordinated by the Australian Nursing and Midwifery Council Incorporated (ANMC), the peak national nursing and midwifery organisation established in 1992 with the purpose of developing a national approach to nursing and midwifery regulation, in cooperation with the state and territory nursing and midwifery regulatory authorities (NMRAs).

Universities also use the standards when developing nursing curricula, and to assess student and new graduate performance. While this facilitates a nationally consistent approach to standards of practice for nursing and midwifery in Australia, differing course accreditation processes across the states and territories still allow the possibility of variability in outcomes of courses leading to initial registration of nurses and midwives. Processes which will continue to improve national consistency in the outcomes of nurse and midwife education need to be developed and implemented with the support of appropriate government policy.

Connecting with other education and training sectors

NSWNA does not wish to provide extensive comment on this issue, except to recommend that the vocational education and training and higher education sectors should continue to have distinctive missions and that movement of students between the sectors should be improved.

Nursing has recently achieved improvements in this regard. Following the National Review of Nursing Education in 2002, national qualifications for enrolled nurses (i.e. the level of nurse education at Certificate IV and Diploma levels in the VET sector) have been developed and implemented as part of the National Health Training Package. These qualifications meet current standards for enrolled nursing by aligning with and reflecting the ANMC enrolled nurse competency standards while meeting the legislative requirements of all states and territories.

The new qualifications have improved articulation pathways with both lower level qualifications and Bachelor of Nursing programs and enrolled nursing and have established possible improved career opportunities for enrolled nurses through the development of an Advanced Diploma for enrolled nurses which provides for advanced and/or specialist enrolled nurse practice in a range of areas.

However, while the new qualifications are facilitating greater consistency in enrolled nursing practice across Australia, significant variability in delivery arrangements for the qualifications still exists between states and territories and amongst providers. These include: varying qualification levels for entry to practice, a diverse range of approved providers¹⁴ and costs of delivery (to students) following implementation of the 2007 Health Training Package (occasionally far in excess of costs encountered by undergraduate students of nursing) .

These variations need to be reviewed so that consistency in course outcomes and articulation processes for movement between the sectors continues to be improved.

Higher education's role in the national innovation system

19. By what mechanisms should research activities in Australian universities be supported?

NSWNA's comments on research activities in relation to nursing and midwifery are outlined in section 2 of this submission.

Higher education's contribution to Australia's economic, social and cultural capital

This feature of higher education is critical. These contributions are made both through the exercise of higher education's core functions of teaching and research and 'third stream' activities as identified in the discussion paper for this review.

As mentioned earlier in this submission, the capacity for the higher education to achieve all its aims has been eroded over the last twelve years. It must now be fully restored and supported so that the diverse roles of universities in education, research and engagement can be realised.

Resourcing the system

The funding arrangements for higher education that existed under the previous Australian Government were not sufficient to ensure adequate resourcing of the system and did not enable the goals of higher education to be met. Public funding provided to the higher education sector has been inadequate and the related compliance arrangements required by the previous government imposed unnecessary restrictions on the sector. These problems now need to be addressed to allow Australians to participate fully in higher education.

¹⁴ As enrolled nursing is a regulated occupation, to deliver EN programs, education providers must be approved by both state training authorities and nurse and midwife regulatory authorities.

While the previous Australian Government's *Backing Australia's Future* higher education reforms proposed increases in public funding of universities, government funding to universities has declined in real terms since 1996 so that the proportion of GDP spent on higher education remains well below the OECD average.^{15,16} The net contribution provided by the Commonwealth Government to funding government subsidised places fell significantly between 1996 and 2005, while the contribution students made to their education approximately doubled¹⁷.

The proportion of Commonwealth funding in the form of grants decreased from 57% (of university revenue) in 1996 to 41% in 2004, while HECS contributions and other fees and charges increased from 12% to 15% and 13% to 24% respectively in the same period. University expenses increased over time but the proportion paid to staff, both academic and non-academic, decreased from 63% in 1996 to 55% in 2004 despite increases in wages for university staff in this period¹⁸.

Universities have clearly struggled to manage the impact of these reductions in Commonwealth funding, and have been forced to expand class sizes and reduce the number of lectures and tutorials in an effort to make ends meet, while precious human and other resources have been consumed in the pursuit of alternative means for raising revenue.

While recognising that some improvements have been achieved in 2007 and 2008, including the establishment of the HEEF¹⁹ and the gradual deconstruction of the HEWRRS²⁰, Universities Australia is advocating immediate and substantial increases in public funding for higher education to ensure a fair, free, prosperous, and sustainable Australia.

NSWNA supports these recommendation but we also wish to emphasise that it is not just increased funding that is required but also improvements in the arrangements and mechanisms for the distribution of funding.

Commonwealth Grants Scheme (CGS)

The CGS provided a clear basis for the distribution of Government funds to universities; however, under the previous government its funding mechanisms were unnecessarily rigid. Within the CGS, universities were allocated a set number of places and funding within each of the twelve discipline clusters (as detailed by the CGS). While this replaced

¹⁵ Australian Vice-Chancellors' Committee, (2005), *University funding and expenditure*, available online at: <http://www.avcc.edu.au/documents/publications/stats/Funding&Expenditure.pdf>

¹⁶ University of Melbourne Postgraduate Association, (2003), *Submission to the Inquiry into higher education funding and regulatory legislation*, available online at: <http://www.umpa.unimelb.edu.au/publications/sub352.doc>

¹⁷ National Tertiary Education Union, (2007), *An analysis of the funding of government subsidised student places at Australian universities 1996 to 2005*, available online at: <http://www.nteu.org.au/policy/submissions/sub2003/4915>

¹⁸ Australian Vice-Chancellors' Committee (2005) *University revenue and expenses by main source, 1996-2004, AVCC Statistics – Funding & Expenditure*, available online at: <http://www.avcc.edu.au/content.asp?page=/publications/stats/fexp.htm>

¹⁹ Higher education endowment fund

²⁰ Higher Education Workplace Relations Requirements

the system of marginal funding for over-enrolments and therefore benefited universities in this regard, it did not result in a net gain in HECS-liable places available to students.

Some universities have not been able to fill their allocated places in some disciplines but have been unable to meet the demand for places in other disciplines (over or under enrolment each attracted penalties).^{21,22} Yet the CGS does not permit universities to meet this demand by shifting allocated places between clusters. Instead, universities are advised to meet this demand by offering full-fee paying places to domestic students. This resulted in an unacceptable loss of opportunities for domestic students and unnecessary inflexibility for universities, however, we appreciate that the current Australian Government is now undertaking to resolve this problem.

Funding arrangements do not reflect course delivery costs

Under the previous government's arrangements for funding of higher education, income received by universities fell well short of the true costs required by universities to deliver their courses²³. Universities were forced to establish complex arrangements to meet the shortfalls in funding by cross-subsidising between disciplines, which placed unnecessary pressure on universities and compromised the quality of educational and other services that can be provided to students.

This is of particular concern for nursing. The previous Australian Government's higher education reforms recognised the urgent need for qualified nurses by identifying nursing as a National Priority area and declared that additional funding must be directed to the costs associated with clinical practice in nursing, but failed to provide this funding. The Deans and Heads of Schools of Nursing across NSW informed us in 2007 that despite recent increases in funding for the clinical component of undergraduate nursing education, there was still a shortfall of approximately \$3,000 per student per year for clinical education alone.

As exemplified by Sydney University's closure of its undergraduate nursing program, universities will not continue cross-subsidies to disciplines, which are chronically and consistently under-funded, if they believe the financial consequences of this process to be too great. This situation was allowed to happen despite the country being in the grip of a critical nursing shortage and recognised by the previous Government's statement that *there is a pressing need to respond to the current shortage of working nurses*²⁴. The current Australian Government has the opportunity to give genuine recognition to nursing as a national priority and resolve the nursing shortage by ensuring that the funding which is genuinely required to deliver quality nursing programs is provided.

²¹ Birrell, B. & Rapson, V., (2006), *Clearing the myths away: Higher education's place in meeting workforce demands*, Dusseldorp Skills Forum, available online at: <http://www.dsf.org.au>

²² Group of Eight, (2006), *2007-2008 Pre-budget submission*, available online at: <http://www.go8.edu.au/policy/papers/2006/Go8%20pre-budget%20submission%2024.11.06.pdf>

²³ Ibid

²⁴ Commonwealth of Australia, (2003), *Our universities: backing Australia's future*, Canberra, p. 18.

HECS contributions for nursing students

The NSWNA supports the inclusion of nursing as a national priority and the implementation of the associated student contribution band, which is intended to ensure that contributions from nursing students remained capped at levels set by the Government, currently \$4,077. However, we know from both students and academics that due to individual university's structures, requirements and philosophies, some nursing students are paying up to \$1,000 more than the capped fee for their education.

While we support flexibility for universities and diversity in our nursing programs, we cannot support a situation that results in inequity for nursing students. The Australian Government must ensure that funding arrangements which guarantee equity for nursing, and other, students are in place.

Funding of clinical disciplines

The NSWNA generally supported the funding clusters that were introduced by the HESA (Higher Education Support Act) as they adequately reflect broad discipline relativities. As stated above however, the Commonwealth funding provided by the previous government within these clusters does not accurately reflect the real cost of providing training in different courses, which is particularly significant for clinical disciplines.

The previous government's funding arrangements provided for a medical student loading, which replaced the old 'teaching hospital grants', to support universities' own infrastructure in teaching hospitals. Clearly, Commonwealth assistance should be available for the clinical teaching of medical students in hospitals; however, it is inexplicable that other clinical disciplines were not provided with equivalent levels of assistance and support. The reason for this situation, we believe, is largely historical.

Clinical disciplines other than medicine require similar, if not greater, levels of university infrastructure in health and other clinical facilities to be able to provide quality clinical education to students. This is most critical for nursing. No other health professionals are more clinically focused or are required to spend more time immersed in clinical practice than nurses. While arrangements for clinical nursing education exist between health facilities and universities, there is not an equivalent level of Commonwealth support provided for the clinical education of nurses.

To reach the level of clinical proficiency required by a beginning registered nurse a sound, quality clinical education is required. This is generally achieved through a combination of on-campus clinical learning, clinical experience in simulated environments and a series of integrated clinical placements in hospitals and other health facilities. The latter requires significant support from both the facilities and clinicians.

Both the previous and the current Australian Governments recognised some of the current difficulties for universities in accessing quality clinical placements for their nursing students, but appear not to have fully appreciated the causes of these difficulties.

In recent years frontline clinical nurses have become increasingly responsible for the clinical education of nursing students. While nurses generally enjoy this element of their work, we know from our members that one of the key contributors to increased workloads is the added pressure of supervising, teaching and mentoring students. Under the current arrangements for the clinical teaching of nursing students, nurses are overwhelmed and struggling to cope with this extra, unsupported responsibility.

This is a direct result of the previous Australian Government's higher education policy and funding arrangements; because universities have not been adequately funded to provide clinical nursing education they lack appropriate hospital infrastructure and are therefore not able to provide appropriate clinical support in hospitals. This responsibility therefore falls to clinical nurses at the bedside. Clearly, there is an urgent need to review the current funding framework and establish a new, transparent framework which accurately reflects the true costs, including clinical costs, of course provision.

Governance and regulation

The NSWNA is not in a position to provide expansive commentary or wide recommendations on the governance arrangements for the higher education sector. However, we support the establishment and maintenance of uncomplicated, transparent governance and regulation arrangements for higher education which facilitate rather than restrict optimum course development and delivery and enable the wider contributions of higher education to be achieved.

These arrangements should include clear processes for quality assurance that set and demand achievement of industry approved and agreed benchmarks and, in the case of nursing and midwifery, facilitate assessment of the quality of an institution and its programs by nursing and midwifery regulatory authorities and other key organisations.