Abstract

Nurses and midwives represent the largest group of health professionals in the Australian health care system. In rural environments nurses and midwives make up a greater proportion of the health workforce than in urban settings, which makes their role in service provision even more significant. The role and scope of these nurses and midwives' practice is by necessity more generalist than specialist, which results in disciplinary strengths and weaknesses. As generalist health professionals they work in diverse settings such as public hospitals, multi-purpose services, community health, aged care and in non-government and private for profit and no-profit organisations including general practices. Their scope of practice covers prevention, intervention and rehabilitation and is lifespan inclusive. Rural nurses and midwives are older than their metropolitan based counterparts, work part-time and traditionally have limited access to professional development often due to ineffective locum relief programs. Workplace inflexibility, access to acceptable housing and partner employment are factors cited as inhibitors to growing this workforces. The future of the rural nursing and midwifery workforce will only be secured if Government invests to a greater degree in both education and training and the development of a nationally agreed remuneration scale that allows for part-time work.

Introduction

Supporting and expanding the rural nursing and midwifery workforce is a growing priority for Australian governments. In rural areas, nurses and midwives play a significant role in the provision of health care services. This group of health care professionals are employed largely in public health care services such as acute care

hospitals, multi-purpose services, community health, aged care and in non-government and private for profit and non-profit organisations including general practices. Contemporary rural nursing practice is lifespan inclusive, traversing preventative, interventional and rehabilitative care. Living and working in their local communities (Mills, Francis, & Bonner, 2007) rural nurses and midwives are highly valued and respected health care professionals who contribute greatly to the social fabric of rural Australia. In this integrative review of the literature we will firstly describe the current rural nursing and midwifery workforce, the impact of tertiary education on the supply of rural nurses and midwives and the challenges faced by these groups. To conclude, we will suggest future strategies to sustain and grow this important element of the rural health workforce with a particular emphasis on government policy development.

Background

There has been a great deal of discussion and research undertaken to describe rural Australians' social, economic and ethnic diversity in order to isolate the peculiar health and lifestyles characteristics of this population. In the early 1990s a seminal report by Humphreys and Rolley (1991) identified health disparities between this group when compared to metropolitan located Australian populations. These authors argued that distance to services was a primary contributor to the poorer health of rural populations. During the next decade, addressing the inequities identified as impacting on the health and wellbeing of rural populations became a key driver for health policy reform (Australian Institute of Health and Welfare, 2008d; Gregory, 1995). The Australian Government accepted that improved health outcomes for rural Australians was necessary and embarked on a limited range of strategies to improve access to

services, and in recent years, realign policy with a primary care prevention philosophy (Australian Institute of Health and Welfare, 2008a). In addition at the beginning of this decade, there was an acceptance that the Australian population was expanding, adding additional burden on the already stressed health care system. Extra numbers of undergraduate health professional places for nursing, medicine, dentistry and some allied health disciplines were supported to meet growing demand (Australian Institute of Health and Welfare, 2008a). Scholarships to assist rural people take up offers for education and training at undergraduate and post graduate levels were also introduced (Banks, 2005) with rural nurses and midwives being the recipients of this funding. The Australian Government also increased the number of places for nursing and midwifery education, particularly targeting regional universities. We would argue however, that the impact of these initiatives on the recruitment and retention of rural nurses and midwives has been minimal. Instead, the continuing nursing/midwifery workforce shortfall has resulted from a broader range of issues than just educational opportunities at a mostly undergraduate level. Issues such as a feminised part-time labour force, lesser opportunities for women, dissatisfaction with the workplace, and limited clinical career pathways are yet to be addressed in a systematic way across the country.

The Current Nursing and Midwifery Workforce

The national nursing and midwifery group in 2007 was estimated to be 305,834 that comprised 245,491 registered nurses and 60,343 enrolled nurses (Australian Institute of Health and Welfare, 2009b). This number represents 40.5% of the entire health workforce (Australian Institute of Health and Welfare, 2009a). An Australian Productivity Commission report in 2005 stated that the health workforce is growing

faster than the general population with the exception of nursing/midwifery and possibly dentistry. This report suggested that this has occurred because of the feminisation and ageing of the nursing and midwifery workforce (Australian Institute of Health and Welfare, 2008b), lower than average working hours, leakage of professionals from the system, a preponderance for specialisation and changes to education and training to enhance qualifications that has extended the pipeline for training of graduates (Banks, 2005). Further analysis of workforce data reveals that approximately 90.4% of the total number of registered and enrolled nurses in Australia are female, and 9.6% are males (Australian Institute of Health and Welfare, 2009b) which represents an increase of 1% in this group since 2003.

The average age of nurses (registered and enrolled) in 2005 was 43.7 years and the proportion of nurses aged over 50 years was 33%, representing a rise of 4.8% for this age range compared to the 2003 data. The average age of rural nurses and midwives is slightly higher than the national figures at 46.1 years (Australian Institute of Health and Welfare, 2009b; Mills, Birks, Francis, Coyle, & Al-Motlaq, 2008).

Even though the Australian nursing and midwifery workforce is ageing, it is also inclusive of at least three generations of employees: baby boomers, generation X and the millennials. On average, nurses fall into the category of generation X, that is born between 1961 and 1981. Together with their millennial counterparts, this group want lifestyle choices and are unlikely even in an era of financial hardship to work in environments that have limited work flexibility and opportunity for career acceleration (Baumann, Zeytinoglu, Akhtar Danesh, Davies, & Kolotylo, 2008). There is a growing discussion in the literature about the impact of generational change on the nursing workforce (Dols, Landrum, & Wieck; Wieck, Dols, & Landrum). It is highly likely and we believe already obvious that the new generation of nurses and

midwives are more discerning than their baby boomer predecessors and will want better working conditions and greater career opportunities that their predecessors. In particular, younger generations want to be led not managed, mentored and supported through positive reinforcement on a daily basis (Wieck, et al.). Managers and leaders of rural and remote nursing therefore will need to evaluate their workplace culture with a view to developing a supportive environment for staff that encourages retention.

Working hours

Workforce data further suggests that the nursing workforce has a large percentage that work part-time or less than 35 hrs/week (46.5%), although the average number of hours worked by registered nurses has increased from 31 hours in 2001 to 33.6 hours per week in the 2001- 2007 period (Australian Institute of Health and Welfare, 2009b). In comparison, the average weekly hours worked by enrolled nurses was 31.9 hours (Australian Institute of Health and Welfare, 2009b). Registered nurses working in rural areas (inner and outer regional areas) worked 32.9- 33.3 hours/per week while those in remote and very remote areas worked longer hours 35.2-39.4 hours. Enrolled nurses employed in rural areas worked between 31.3-31.8 hours per week and those in remote and very remote areas worked 34.2-35.8 hours per week (Australian Institute of Health and Welfare, 2009b). Overall, the nursing workforce in rural and remote areas has demonstrated a marked increase in working hours as compared to the previous nurse labour force data report (Australian Institute for Health and Welfare, 2008). Although nurses in remote areas have traditionally worked longer hours than those who also work part-time in rural areas hours, those considered part-time are now working on average close to full-time equivalent hours, which is a reflection of the context of their work.

The literature suggests that nurses working in rural areas are more likely to be part-time than remote area nurses and to take breaks when family commitments supersede the need to supplement family income (Henwood, Eley, Parker, Tuckett, & Hegney, 2009). As nursing and midwifery is a predominantly female profession, it is not surprising that part employment and regularity of working hours dominate the needs of these employees. Accommodating individual's requirements for flexible working hours has not been a strong feature of most health workplaces however, with increasing shortages and changed attitudes about work/life balance by the new nursing and midwifery graduates, the landscapes are adjusting.

Implications of being a Generalist workforce

Health care practice in the rural context is largely generalist in nature, meaning that rural clinicians; nurses, midwives and medical staff provide initial services to entire populations that cover pre-conception to death and bereavement (Bushy, 2002; Hegney, 2000; Henwood, et al., 2009). Specialisation as a preferred career advancement strategy impacts on rural employer's capacity to recruit and retain nurses and midwives. Rural practice is promoted as generalist in nature with many graduate programs limiting experience to general units. Career advancement opportunities, being acknowledged by the profession, other health colleagues, and employers are all important strategies for enhanced job satisfaction**.** Access to locum relief programs, housing, spouse/partner and child care support, and incentive payments for practice in challenging contexts (Penz, Stewart, D'Arcy, & Morgan, 2008) are also important but usually only offered to nurses working in remote areas of Australia. A recent study by Henwood et al (2009), undertaken in Queensland,

found that nurses working in outer regional/remote/very remote contexts became disenchanted with the workplace and felt stressed when they were unable to take leave or access continuing professional development programs because of an inability by their employers to back fill or engage locum staff to cover staff absences (Henwood, et al., 2009). This same study (2004) also found that when relief was not provided for staff taking leave, on their return to work they faced increased an workload that then escalated nurses' levels of stress and dissatisfaction with the workplace.

Meeting the currency of practice requirements

As a regulated profession it is encumbered on all who are deemed members through licensure to practice safely and within the parameters established through legislation and agreed workplace policies. As a federated nation each State/Territory is subject to specific legislation that includes provision to regulate nursing/midwifery. The establishment of a national body, known as the Australian Nurses and Midwifery Council (ANMC) provided a vehicle for national standards and codes for practice to be developed. Supporting the nursing/midwifery workforce to achieve the highest possible standards for practice has until recently been managed by the regulatory authorities in each of the States/Territories, albeit the processes adopted have been lenient in terms of expectation and monitoring of currency. The profession however has become more concerned with practice standards and there is increased surveillance by regulatory authorities of registrant's currency of practice. As has been highlighted earlier, the rural and remote nursing and midwifery workforce has and continues to cite access to continuing professional development programs as a workplace frustration and stressor and potentially a reason for leaving practice and/or

reducing hours of work (Bushy, 2002; Henwood, et al., 2009; Mills, et al., 2008), in relation to the ability to maintain currency of practice, this issue is of major concern.

Graduate programs

On completion on pre-service undergraduate nursing/midwifery programs the majority of graduates undertake a graduate program. These programs provide varying levels of support to graduates in transitioning from the role of student to registered nurse. As comprehensive registered nurses, graduates maybe employed in any context, however most choose to commence their careers working in the acute care sector. Across Australia, choices afforded graduates when applying for graduate programs vary and maybe dependent on the size and location of the healthcare facility and the nurse leader's past experience. In their recent review of the status of rural nursing Mills, Birks and Hegney (2010) found that restricting graduates to 'safe' or organisationally deemed appropriate areas leads to graduate dissatisfaction and can impact negatively on retention rates of staff. Many rural health services provide broader range experience to new graduates as a recruitment strategy. The success of this approach is patchy with some employers measuring success as keeping new graduates for one to two years.

Tertiary Education and its Impact on the Supply of Rural Nurses and Midwives

It is now almost twenty years since the Australian government announced that nursing and midwifery education would be undertaken in the tertiary sector (Mills, 2009). The current workforce is inclusive of staff who were trained in the hospital-based apprenticeship model and those who have completed vocational education or

university pre-service educational programs leading to licensure as a registered or enrolled nurse. For many years the loss of student nurses filling workplace need was lamented as shortages of trained staff were noticed and the impact on service delivery intensified (Minchin, 1977). The pipeline impact while initially not significant intensified as the numbers of apprenticeship trainees working in hospitals diminished. Reliance on other workers such as assistants in nursing or domestic staff to undertake tasks such as making beds, serving meals, replacing water utensils, cleaning equipment and utility areas that had traditionally been allocated to trainee nurses shaped a new workplace milieu.

The rift between education providers and industry widened as the responsibility for clinical skill development of students oscillated between the two sectors. Educationists argued that expert clinicians were in practice and that they had a professional obligation to assist in the education of tomorrow's workforce, while health services maintained that their business was service delivery not pre-service education (McCoppin & Gardner, 1994). In some jurisdictions funding was provided as an incentive to health service employers to support the clinical education of students throughout their pre-service programs. Over time it appears that some of these initial tensions have disappeared as each partner has realised that they are co-dependent on one another, although the cost of clinical education continues to rise. It is anticipated that the minimum number of clinical hours in pre-service bachelor programs will decrease as access to appropriate clinical venues and associated costs become unsustainable (Preston, 2009). It also likely that simulated environments will be used to a larger degree to teach students clinical skills and for them to practice as time in clinical venues during pre-service education reduces (Alinier, Hunt, Gordon, & Harwood, 2006).

The decision to support the transfer of pre-service registered nursing education to the tertiary sector while important for the evolution of the profession of nursing and midwifery challenged government to plan for workforce shortfalls as a result of the separation of education and industry needs (Heath, 2002). Nursing welcomed new opportunities that a tertiary educated workforce afforded while industry and government were forced to rethink the value of the nursing and midwifery workforce and offer incentives to potential future employees. Investing in the education of nurses and midwives was identified as a necessary step to ensure a sustainable and appropriately qualified workforce although there was concern that attracting students to nursing programs would be challenging if the image of nursing as a vocation rather than a profession continued (Crowley, 2002; Heath, 2002; Reid, 1994). To encourage school leavers to undertake nursing education, students were initially exempt from higher education fees imposed on tertiary students to cover some of the costs of their education. Scholarship programs were also offered to students in rural and remote areas as incentives to attract them to nursing/midwifery and ensure reasonable access to programs. These programs while acclaimed as a step in the right direction have never been funded to the level of medical pre-service education. The professions' acceptance of 3-year educational program for registered nurses was a compromise to ensure government support for the transfer of nursing education to the tertiary sector. Twenty years on, the questions we as a profession now need to ask are:

1. Are 3-year pre-service programs adequate?
2. Do current models of clinical education that are largely a block release approach meet the needs of students and employers?

Answers to these questions have resource implications and as such continue not to be provided, however in an era when demand continues to outstrip supply, the nursing and midwifery profession is in a position of power, it is time for government to listen

to these questions and allow the profession and industry to plan a strategic response that will prepare a future workforce for contemporary practice. Even though recent reforms in clinical education and placement have begun to touch on the second question there is still more work to be done. Health Workforce Australia the body charged with this reform has stated that rural and remote workplaces will be prioritised in funding rounds (Health Workforce Australia, 2010), however at this point it is too early to tell if this will translate into reality.

Strategies for Sustenance and Growth

In rural areas of Australia many health service employers have adopted greater flexibility in terms of working hours. The Australian Institute of Health and Welfare in an earlier report on nurse labour force concludes that the numbers of nurses and midwives may have risen but that the impact of this growth on workforce shortfall has been limited. They suggest that one of the key reasons is that the majority of nurses and midwives, particularly in regional areas work part-time (2008c). Many rural health care services have been forced to think creatively about recruitment strategies that account for a work life balance employing marketing agencies to produce campaigns that sell not only the employing agency but also the region, highlighting the lifestyle advantages of living and working in the country.

Even with improved local marketing strategies, attracting nurses and midwives to work in rural areas is an ongoing challenge for many rural health services. Some employers have modified traditional recruitment strategies that are no longer successful Instead individual employment packages are becoming more common with incentives including short-or long term accommodation, access to child care, and in some cases spouse employment to name a few. Health services recruiting overseas

trained nurses to meet workforce needs sometimes provide community located furnished accommodation and transport to and from work to their place of residence (Francis, Chapman, Doolan, Sellick, & Barnett, 2008) to ensure the retention of staff.

Many studies have identified comprehensive orientation programs as a motivator to continue working for an organisation. These programs ensure new staff are knowledgeable about the environment and understand the governance arrangements of the employing organisation and the limitations placed on their practice within that facility (Mills, et al., 2010). As highlighted previously though, access to continuing professional development programs is difficult for many rural nurses and midwives often because of geographic distances and/or direct and indirect costs (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002; Mills, et al., 2008). Yet, nurses and midwives as professionals have an obligation to ensure that their knowledge and clinical skills are current. Most health services are required to provide access to mandatory training for targeted activities such as cardio pulmonary resuscitation. As well there is a growing acceptance of the need to invest in additional resources to support currency of practice. Increasingly the employment of nurse/midwife educators, access to online databases, institution based libraries and meeting the costs associated with providing on site continuing professional development, are strategies used to improve the retention of nurses and midwives in rural workplaces.

The Way Forward

The challenges for rural health services in sustaining a nursing/midwifery workforce to meet needs are many. It is unlikely that the gender balance will change in the immediate future making a feminised workforce who prefers to work part-time an ongoing issue. Developing mechanisms that permit nurses and midwives to

balance their professional and personnel lives will be more necessary than it has been in the past (Krebs, Madigan, & Tullai-McGuinness, 2008; Squires, 2001). Ensuring that nursing and midwifery staff have real opportunity for career advancement that is understanding of their need to be part-time employees must also be a priority for employers, the profession and government if attrition is to be arrested.

As workforce shortages become more apparent it is likely that there will be increased blurring of roles. In recent years there has been an expansion of the scope of practice within registered and enrolled nursing roles. Registered nurses in advanced practice roles are able to prescribe medication, initiate investigations in order to confirm a provisional diagnosis and refer to other service providers. Many of these new roles have traditionally been the domain of medical doctors. Endorsed enrolled nurses in most jurisdictions are now able to administer and manage a limited range of medications, including intravenous venous medication. This expansion of nurses' scope of practice is generally associated with increased knowledge and skill at the beginning level and an expectation that clinicians extend their capacity throughout their careers (NBV, 2008). Providing support to nurses and midwives to meet their obligation for currency of practice will be necessary if the workforce is to be sustained. Management will need to think about in-house methods to support continuing professional development and processes to enable staff to access external initiatives that they identify as important.

As the roles of nurses and midwives have evolved so to, have the expectations of the general public. Access to information technology and an associated consumer demand to be provided with relevant and accurate information is impacting on the practice of all health care professionals. Nurses and midwives are accountable and as such need to ensure that the information and the services they provide are evidenced

based and understood by their clientele. Employers have a responsibility, to provide resources that support staff's access to evidence and capacity to undertake research to inform practice. Further, employers will need to increase resourcing to ensure that clinical guidelines and protocols are contemporary and reflective of best practice.

For much of nursing and midwifery's history in Australia workplace demands have dominated workforce planning and working conditions. The new millennium heralded great changes that have, and will continue to impact on the lives of the Australian population and more specifically nurses and midwives. Government has accepted that climate change, a down turn in global economies, the increasing longevity of the population and associated escalation of morbidity particularly chronic diseases requires a rethinking of traditional methodologies to ensure growth and prosperity of the nation that is shared by all. National health priorities have been adjusted to reflect the need to reposition health care as prevention focused service. Preventing ill health it is argued will limit the investment in acute care services that may be beyond the nation's capacity to meet. Interventions that could be avoided if a well population philosophy underpinned service delivery (Francis, Chapman, Hoare, & Mills, 2008). If this ideal is to be realised education providers will need to reconceptualise pre-service and post-graduate education and employers reprioritising services offered and the staff mix and skills required to deliver these. Educationalist and accreditation authorities will need to be more flexible to meet the needs of rural students undertaking pre-service programs. There are a small number of bachelor of nursing programs that are offered largely in the distanced education modality. It is likely that flexible delivery pre-service programs will dominate the landscape in the future. Ensuring that students are well educated, clinically competent and have a 'real' university experience will be the challenge in this environment.

If the rural nursing and midwifery workforce is to grow a detailed clinical career pathway that is inclusive of specialisation in a rural context and associated remuneration must be developed. Employment packages that offer family opportunities and provide for work life balance will need to be offered.

Rural Australia is a rewarding context of practice requiring clinicians to be highly skilled and knowledgeable. To accommodate the needs of a rural health workforce, pre-service programs will need to isolate the differences in practice contexts and modify curriculum accordingly. Double degrees that offer students dual careers or specialisation on registration will become a feature of this new landscape, challenging employers to consider different workforce skill mix, roles and responsibilities. Higher-level skills will need to be taught and graduates allowed to practice utilising their full range of skills when they enter the workforce. Partnerships between education providers and industry will need to be stronger if graduate nurses and midwives are to see rural practice as a career choice.

Conclusion

Workforce data suggests that the current workforce is not being replaced. Replacement of the current nursing and midwifery workforce is doubtful unless the context of practice changes to meet the needs of new generations of nurses and midwives. Career advancement opportunities, acknowledgement by the profession, health colleagues and government of the work these employees undertake, greater support of undergraduate and post graduate specialisation education programs and individuals accessing these, efficient and accessible locum relief programs, housing, spouse/partner and child care support, and incentive payments must be offered as the norm not the exception. Reversing the gender imbalance may follow on from the

implementation of these strategies if the career structure for nursing and midwifery is addressed and the image enhanced to reflect a dynamic, well-educated, autonomous profession that is valued and impacts positively on the health and wellbeing of all Australians.

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