Good afternoon. I am deeply moved and honoured by my colleagues for inviting me to present this oration. I thank the Australian College of Nursing for this privilege.

As many of you may know, I have recently retired following more than 50 years in nursing. I therefore thought it was an opportunity to reflect on the major changes and advancements that have occurred in the profession of nursing and in health care generally during those 50 years. In so doing, I am also cognisant of the theme of this National Nursing Forum which is “Advancing Nurse Leadership”. My intention therefore is to examine the major themes that shaped our profession concentrating on leadership and access to healthcare.

When I reflect on the early days of my career, we were embattled as there was little support from the other health professions who were keen to see the status quo being maintained. This experience of conflict inevitably led to a situation of change only being brought about by conflict, a situation which, to a degree, exists until this day. We had internalised notions of being seen as followers and not leaders in changing health care. We were clearly in need of some consciousness raising to reverse this situation.

Of course, where we were at the beginning of this 50-year period was to a large degree shaped by our forebears, particularly following the Second World War which had such a significant effect on the delivery of health care and on the development of our profession. For example, it was in 1949 the two colleges of nursing (the forerunners of the Australian College of Nursing) were established by nurses who had the vision to lay the foundations for the eventual move of nursing education into the higher education sector.

One of the beacons of nursing and a great leader in the immediate post-war period was Vivian Bullwinkel whose remarkable heroism on the shores of Bangka Island and later in a prisoner of war camp in Malaya forged a new understanding of the role of nurses, both during the war and in the 1950s and 1960s.

The 1950s saw the first Aboriginal and Torres Strait Islander nurses, such as Sadie Canning and Lowitja O’Donoghue, finally being given permission to undertake and complete their nursing education. Prior to this time those who wished to provide nursing or midwifery care were confined
to working as assistants in nursing and in that role mainly taking care of Aboriginal and Torres Strait Islanders rather than the broader population.

I must also mention Olive Anstey, who was the Director of Nursing at the Sir Charles Gairdner Hospital in Perth, who made a major contribution to nursing at the international level by being elected President of the International Council of Nurses (ICN), the second Australian to hold this position. She had been preceded in this arena by Susan McGahey who had formerly held the position of Matron of the Royal Prince Alfred Hospital and who was elected President of ICN in 1904. She was the first Australian in this position.

I have chosen just a few examples and individuals to illustrate our rich history, mainly during the second half of the 20th century, but there are many more who contributed to developing a framework for what was to come.

On taking up the presidency of the International Council of Nurses, each president chooses a watchword, the purpose of which is to guide the forthcoming quadrennium. My watchword was “access” which was applied to a variety of different activities. For me, its principal application was placing a focus on inequality of access to health care, which is a worldwide issue, and the role of the nurse in reversing this. Of course, it can be broadened to apply to other activities such as access by nurses to continuing education, access by governments to nursing policy advice and access by nurses to just and equitable working environments. I propose to use this concept of access as a lens through which to frame this oration.

So to begin I propose to take us back to 1948 to the Universal Declaration on Human Rights which was adopted by the General Assembly of the United Nations. Included in the declaration are, amongst other things, the right to social security, health and education, as well as racial equality and equality between the sexes. The latter was to have a profound effect on the development of nursing as we became swept up in the women’s movement and the rise of feminism in the ‘60s and ‘70s.

Health as a human right is fundamental to the concept of access to and indeed equity in health care. Universal access to health care in Australia was introduced as part of the reforms of the Whitlam Labor Government in 1975 under the rubric of Medibank. Whitlam drew on the UK Beveridge Report (1942) which had recommended the establishment of the National Health Service as the benchmark for Medibank which was amended to Medicare in 1984 and became the universal health care scheme in Australia. It has seen a number of iterations but the fundamental thrust is to provide free access to hospitals and subsidised access to medical practitioners, nurse practitioners, optometrists, eligible midwives and some dental services. Alongside Medicare is the Pharmaceutical Benefits Scheme which was introduced in 1948 by the Chifley Labor Government. The latter is the envy of many
countries. In the post-war period we also saw profound societal changes such as smaller families, increases in the standard of living, the rise of feminism and changes in education, particularly at university level. Nursing, principally as it is a female dominated profession, was affected by all these changes. I shall explore this theme presently. Nurses played a significant role in universal access to health care as they were central to the implementation of new and expanded health services.

In the face of growing inequity in access to health care, last year the World Health Organisation called upon its members to work towards achievement of universal health coverage rather than access being determined by ability to pay. There is an ongoing tension in our own country about whether we wish to continue with the existing benefits of Medicare for our citizens.

From the 1960s hospitals began to develop into the hospitals we know today. I recall the establishment of the intensive care unit at my training hospital and the introduction of the first dialysis machines. I then undertook one of the early intensive care nursing courses in London at the time of the moon landing. Whilst we all know that the justification for hospitals is to provide nursing care which cannot be delivered in the home, the role of the nurse intensified and nurses needed to deliver care which was more than providing comfort. They needed to become technically competent and move to a plane where nursing diagnosis and interventions contributed to patient outcomes. Inherent in this is the need for nurses in the acute setting to prevent the occurrence of adverse events.

Along with the rise of the modern hospital, we saw profound technological change. We were able to keep critically ill patients alive through mechanical ventilation, through early diagnosis and treatment of cardiac arrhythmias, and through the administration of chemotherapy and carefully calibrated radiotherapy. If nurses were to maintain their role in patient care they had to become educated in the care of patients through these treatments and resist the rise of technicians who cared for specific aspects of a patient’s care. Wholistic care was paramount.

Advances in technology began with the development of artificial hips and intraocular lenses. These were followed by the development of various materials in the form of heart valves, stents, arterial bypasses and pacemakers. Nurses once again had to rise to the challenge of providing expert care both postoperative and rehabilitative. They enabled these advances in health care by coordinating care and preventing complications.

Profound technological developments have been in the field of pharmaceuticals, especially antibiotics. The latter have transformed paediatric care with the effect that the childhood mortality rate has declined, the outcome of which is increased life expectancy and a decline in age adjusted mortality. Conversely, we now have a situation where health professionals are encouraged to dispense prescriptions for antibiotics judiciously as the incidence of antimicrobial resistance has risen rendering
some rare infections impossible to treat. In particular, close to home, is the situation of multi resistant tuberculosis in the Torres Strait and Papua New Guinea.

We now see demographic change in the form of an ageing society and the rise of degenerative disease occurring alongside the recrudescence of quiescent communicable diseases such as influenza and viral haemorrhagic fevers. In addition, we also see a rise in non-communicable diseases.

The majority of the elderly population wish to stay in their own homes but as they age their health care needs increase. Furthermore there is an increase in the number of those living alone. They need to be educated on how to avoid pitfalls and maintain their mobility. Nurses are the main health caregivers for this cohort. Once again we see nurses expanding their repertoires and becoming expert in the care of a specific segment of the population.

Our society, along with others, has a rise in diabetes, obesity and other like diseases and malnutrition. Nurses now are being encouraged to use their knowledge to assist patients to modify their lifestyles and turn the tide on the rise of these conditions. The concept of the primary health care nurse is relatively recent and once again provides another avenue for expansion of the nursing role. Nurses are ideally placed to provide wholistic interventions for those in the community, either as direct care givers or as coordinators of care.

Perhaps one of the more significant roles for nurses is the care for those who have immune compromised states as a result of therapies for malignancy, inherited conditions, HIV/AIDS and transplant patients. Careful nursing care for this cohort can often mean the difference between life and death.

Midwives are playing an important role in access to health care for women and their families. In recent times we have seen a push to decrease the medicalisation of birth and provide a more relaxed setting with an emphasis on natural childbirth.

The digitisation of health care information and the aggregation of data enabled opportunities for advances in health care. It has helped us to diagnose more accurately and provide more effective care. Nurses are the guardians of this technology when applied directly to patients in the form of ventilators, monitors of all types, drug delivery systems and so on. Nurses are expected to manage this technology and troubleshoot when it goes awry. Nursing research bloomed and nurses were expected to undertake research as a component of their studies. Nurses recognised qualitative research as being as important as quantitative research.
Returning to the theme of enabling access to health care, I now shall concentrate on the development of the nursing profession. In the ’70s and ’80s there were several major drivers to transfer nursing education from the hospital or service sector into the education sector. The overwhelming reason in the beginning was the realisation that with rapid technological change taking place within the health system, nurses needed a much broader and deeper educational base if they were to function with technical competence whilst continuing their role in providing care to patients and their families.

It was clear that if the profession were to contribute on an equal basis to the health care debate, there was need for them to move from being unsophisticated epistemologists to possessing a more comprehensive understanding of the political economy of the health system and their potential to change it.

What was not as evident and did not play a part in the campaign was the gradual realisation by the funders of the public hospitals that nursing education in the form of apprenticeship training was a significant drain on the health budget. Student nurses were the backbone of the nursing workforce in the public hospital system as well as in a decreasing number of private hospitals. On the other hand they were paid to spend an increasing amount of time both sitting in classrooms and gaining clinical experience in settings outside the acute hospitals. It was evident that the changes sought in Australia were already taking place in parts of the United States. Pressure was applied by the local state/territory nursing boards in the form of gradually increasing the number of hours and the content in the curriculum. From another but more individual perspective, nursing education was outside the mainstream education framework which had the effect that those nurses who no longer either wanted to practise or who wanted to undertake a degree in a university had a qualification with no articulation to the wider education system.

The campaign to transfer nursing education into the education sector began in 1973 with a small group of nurses representing all the major nursing organisations in Australia coming together to devise a plan of action. Prior to this meeting, conflicting views on the way forward had been advanced resulting in surprisingly no progress! Nursing leadership was paramount in achieving a consensus on how to proceed. Not only were there differences between the nursing organisations but as always the state/territory supremacy also came into play.

Following this meeting, a document – in fact a manifesto – entitled The Goals in Nursing Education – Part II was developed and formed the basis for a concerted and highly organised national campaign. Lobbying materials were produced and a plan to approach every federal politician and those standing for election was developed in each of the states and territories. As a more junior member of the profession at the beginning of this campaign, I had my eyes opened as I traipsed around politicians’ offices outlining the advantages of transferring nursing education into the higher education sector.
Truth needs propaganda as much as the opposite! My lobbying skills were somewhat rudimentary then but persistence was the driver. The resistance from politicians was enormous, spurred on it seems by their constituents and their families. It is from that time that I realised that every politician has either a nurse in the family or at least one next door!

As mentioned, the campaign began in the '70s which was around the time of the second wave of feminism, which was part of a general liberation of all oppressed groups such as homosexuals and those with coloured skin. You may recall that Germaine Greer’s seminal work *The Female Eunuch* was published in 1970 and this set the scene for women demanding the same rights as men enjoyed both in Australia and overseas. We were caught up in that movement as, with nursing being overwhelmingly female, the campaign to transfer nursing education became a feminist issue. Anne Summers, another famous Australian feminist and author, had a later role to play in this struggle.

During this period there were two cases in the Industrial Commission in 1969 and 1972 on equal pay. The first was equality of pay between the sexes and the latter equal pay for work of equal value. Numerous cases to increase salaries for nurses were mounted during this period and more recently. Nurses became more aware of their centrality to the health system and demanded rightly to be properly remunerated. Cases for salaries and conditions which were more in line with similar occupations in the wider community continued at both state and national levels throughout the 1980s and 1990s until the present. Gradually nursing and midwifery wages caught up with expectations, although time lags were frequent.

The campaign to transfer nursing education was long and hard waged during and between elections. Success was finally achieved nationally on 24 August 1984 when in-principle support was given for the full transfer nationally. This was a significant hurdle but more hard work was yet to come. The hospitals and state/territory health departments heaved a sigh of relief as the cost of maintaining an apprenticeship nursing program had been increasing. An Interdepartmental Committee was established in Canberra as this transfer involved the movement of state/territory health funds to federal education coffers. Anne Summers, who at the time was head of the Office of the Status of Women in the Keating Government, was a strong advocate and ensured that the process did not stall.

This campaign is emblematic for us on several levels. First and foremost it showed that we have a tradition of formidable leaders in nursing and midwifery. I began by mentioning the nursing leaders who had the vision to establish the two nursing colleges in 1949. As they are all no longer with us, we cannot ask them if they foresaw the transfer of nursing education from the hospital sector but I suspect that some may have. Second, it also showed that determination, hard work and consistent messages are required if a vision is to be realised. This campaign took the better part of 11 years with
elections coming and going and powerful forces opposing us. The Country Women’s Association and some factions of the Parliamentary Labor Party as well as, it seemed at the time, the whole Parliamentary Liberal Party all fought against us. In addition to the presence of feminism in the debate, elements of class warfare also emerged. Opponents, particularly from the union movement, ran a campaign citing disadvantage for girls from lower socioeconomic backgrounds not having the opportunity to be paid while they trained. Their prediction was that nursing would become an elite profession and that women would be denied a career which was flexible and sustaining to many families, particularly in straightened economic times.

The transfer agreed to in 1984 was then debated at individual State and Territory level. All jurisdictions except Queensland put plans in place to facilitate the transfer with New South Wales the first to achieve total transfer. Queensland eventually followed. Initially the programs were established in colleges of advanced education at diploma level but the ultimate goal was bachelor level. Another battle ensued and this time the goal was accomplished fairly quickly along with other changes to higher education. Thus we were on the way to educational parity with other health professionals at an early stage which was to stand us in good stead down the track. I am referring here to the National Registration and Accreditation Scheme, where nurses and midwives are on an equal footing with other health professionals. I think our status would have been different had we not required a bachelor degree as the basic qualification. We also achieved uniform entry to practice at a very early stage.

In the end, it is sobering to contemplate that funding and the Commonwealth versus the States and Territories ongoing budget debates were the key factors in its resolution. That is not to dismiss the urgent need for nurses to be educationally prepared in a mainstream setting where they were grounded in technical subjects as well as the traditional and fundamental functions of nursing.

Once the question of the location of the foundational programs in nursing was settled, postgraduate programs gradually followed to the point today where we have large faculties of nursing and midwifery with a wide range of offerings. The effect of this has been to enhance access by nurses and midwives to education, particularly specialist education. Online formats are readily available and those who live in the more sparsely populated areas of Australia have access to programs on the same basis (internet access permitting) as their metropolitan counterparts. Access to health care by the population is also enhanced as nurses and midwives gain qualifications which enable them to provide specialised care in a range of different settings. A good example of this is that in the far north of Western Australia a paediatric nurse practitioner has established a service whereby the majority of babies needing care in a neonatal intensive care unit can remain in the local hospital. The effect of this is that the families of those neonates no longer need to travel thousands of kilometres to the capital thus disrupting family life. Moreover, the costs to both families and the health service are greatly diminished.
These momentous changes to nursing education inevitably opened opportunities for nurses and midwives to expand their roles. I do not intend to discuss the many areas in which nurses practise, nor their enhanced roles. The latter are always evolving. Nevertheless, it is clear that with strong undergraduate preparation, nurses and midwives are equipped to adapt to the changing health care environment. One could comment, “So what? Why would this not be the case?” My answer is that we cannot rest on our laurels and hope for the best. It is critical that we maintain flexibility and a willingness to adapt and take on new roles. If we do not then others will step in and take our profession from us. That sounds a bit dramatic but we have seen incursions into nursing and midwifery largely from emerging health professions in both the United States and Britain. In Australia, there has been a push to introduce physician assistants – a move which has no discernible advantage given the current components of the health workforce and which is clearly driven by ideology. Policy development of the health workforce with its attendant competing imperatives is one of the significant contemporary challenges facing nursing and midwifery as we struggle to maintain professional standards and relevance at the same time.

This brings me to the issue of leadership as we need to ensure there are visionary nursing leaders throughout the profession. It goes without saying that we need cooperative relationships between the various strands of nursing and midwifery and we have good role models from our past history in achieving this. I cannot let this occasion pass without mentioning the cooperative relationships forged between the major nursing bodies in Australia. With any group or organisation of like-minded individuals or professionals, there is always the possibility of internal dissension. Nursing has certainly had its share of internecine fighting, often played out in the courts. In recent times, good sense has prevailed and the leaders of the various groupings have shown significant leadership in creating partnerships and making sure they are maintained.

One of the pivotal leadership positions is that of the governmental chief nurse and midwife. We are fortunate to have a good record of nursing and midwifery leadership in all jurisdictions except the Commonwealth. However, the latter situation was addressed in 2008 with the establishment of the position of Commonwealth Chief Nurse and Midwifery Officer. The profession worked long and hard to achieve this position.

Whilst we have achieved much in both the development of health care and of nursing and midwifery, there are still challenges in both areas. We are in the midst of a debate about the ongoing funding of our health system with questions being asked about its affordability. Nurses and midwives must contribute to this debate if our commitment to maintaining access to health care is to continue, as it is the vulnerable who are most affected when health services are curtailed. We are on the brink of significant expansion of nursing and midwifery roles in the community. We also face challenges in
education, particularly in the undergraduate nursing curriculum as pressure from many quarters is applied to include emerging speciality fields in a curriculum which is already bursting at the seams. I am sure that the three-year versus four-year undergraduate program debate will emerge again!

I have pointed to the main developments leading to the evolution of our profession over the past 50 years. There are many factors which have influenced our progression. That said, my view is that the transfer of nursing education into the mainstream and into universities is the most critical factor in our development in my lifetime. I hope that I have illustrated that a broad scientific basis to our practice is the foundation of our past success and our future development.

We inherited a situation where powerful, innovative nursing leaders took advantage of the opportunities for nursing when they were presented. I am confident that this tradition will be carried on and that we have the nursing and midwifery leaders to guide our professions judiciously to increase access to health care for our community.

References


