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Pursuing an Australian Nurse Practitioner Career: Barriers and Enablers

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A B S T R A C T

Nurse practitioners (NPs) are valuable health care sector contributors. However, barriers and enablers to becoming an NP in Australia are poorly understood. To better understand these barriers and enablers, semistructured focus groups were conducted at a professional symposium for nurses, NPs, and NP candidates/students. Responses were thematically analyzed. Transcripts included 20 participants from regional and rural areas and generated the themes "Pathway Clarity" and "Financial Viability." Providing clear pathways through training, endorsement, and credentialing, structured on-site training programs, and funded positions for students and preceptors are support training outcomes for NPs, therefore maintaining and growing a high-quality NP workforce.

Introduction

Nurse practitioners (NPs) are a relatively new addition to the Australian health workforce, with NPs first endorsed to practice in December 2000.[1] Australia provides free health care to everyone in Australia via Medicare, which is funded by a levy of up to 2.0% of each individual's taxable income. There are >2,500 Australian NPs working across multiple clinical areas, including aging and palliative care, chronic and complex care, child and family health care, emergency and acute care, mental health care, and primary health care.[2,3] After graduation from an approved NP graduate program in Australia, which requires the completion of 300 hours of supervised clinical practice placement, NPs are then endorsed by the Australian Health Practitioner Regulation Agency and apply for recognition by Services Australia to obtain a provider number (to allow for billing for services) and prescriber number for Pharmaceutical Benefits Scheme (to enable prescription of government subsidized medications under the Pharmaceutical Benefits Scheme). Using the full nursing scope of practice can help reduce the burden of the increasing demands on the health care system.[4]

Barriers to NPs working to their full scope of practice include a lack of peer networks and support, resistance from medical officers, deficiency in funded training positions, inadequate designated preceptors time, and insufficient support from their organizations and other health care workers.[5,6] Further barriers in the Australian context include limited access to the Medicare Benefits Schedule and reduced authority to prescribe through the Pharmaceutical Benefits Scheme.[7] NPs relative scarcity, flexible roles and scope of practice, and unclear training pathways result in them being poorly understood by health care workers and the wider community.[5] These barriers prevent NPs from fully contributing to the health care system.[5,7,8]

Reduced awareness and transparency of NPs' scope of practice is partly due to nonuniform approaches to NP education.[4] Consequently, NPs have inconsistent clinical knowledge, skills, and capabilities—even among NPs within the same practice area.[4] Structured expectations for ongoing education and development after graduation from a master of NP course are also lacking in Australia. This is unfortunate, because structured in-house NP education programs with preceptorship arrangements and continuous targeted skills and knowledge assessments improve new NPs' confidence, competence, and transition into practice.[9] Furthermore, the capacity of these NPs to provide higher level care develops more rapidly, therefore improving patient safety and enhancing organizational rate of return on investment.[9]

Pathways into the Australian NP profession are demanding, complex, and sometimes lack clarity. Australia NP endorsement requires unconditional general registration as a registered nurse, 5,000 hours of recent and relevant advanced practice experience, completion of a program of study approved by the Nursing and Midwifery Board of Australia, and compliance with the NP registration standards for practice.[10] Australian university master of NP enrollment applications require endorsement by a hospital and written commitment from a clinical support team comprised of appropriately experienced clinicians who commit to providing educational support for the duration of the student's course. NP students in Australia are then provided with a generalized course applicable for all NPs, regardless of specialty area, with clinical skills taught by each NP students' clinical support team.

Variable processes across employers add further complexity. Procedures after conferral of an NP qualification include endorsement by the Australian Health Practitioner Regulation Agency in addition to local credentialing—a process that verifies the

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clinician's qualifications, experiences, and ability to provide safe, high-quality health care.[11]

Purpose

Barriers and enablers to education and recruitment pathways (eg, enrollment pathways, variable scope of practice, funding and time constraints, and education programs structure, etc.) are not well reported in the literature. This study explored the experiences and perceptions of Australian rural and regional nurses, NP candidates, NP students, and NPs of the barriers and enablers faced by nurses pursuing an NP career.

Methods

Methodology and Research Design Overview

This study was conducted using qualitative phenomenological methods. This research paradigm acknowledges that there are multiple realities and truths that can be understood by examining a participant's subjective (first-person) experiences.

Data were collected through 3 focus groups with participants from regional and rural areas. Focus groups were timed to coincide with a professional symposium for NPs and prospective NPs in 2024 to enable in-person data collection. Participants joined 1 of the 3 groups based on their experience. Experienced NPs (ENP) included those who had been working as NPs >1 year, novices (NNP) included those who had completed ≥1 year of their NP training or had <1 year experience as an NP, and students (SNP) included those who were less than 1 year into their NP training or were considering enrolling. Before commencing the focus group, participants completed a paper survey to collect demographic information.

The Darling Down Health Human Research Ethics Committee granted approval for this study (LNR/2023/QTDD/101655).

Participants

Participants were nurses, NP candidates, NP students, and NPs working in public or private health care services in Australia and attending the professional symposium. Inclusion criteria were holding a nursing qualification, being aged ≥18 years, and current or previous experience working in a regional or rural health service. NP candidates and NP students are nurses enrolled in a master of NP qualification program and undertaking working placement with a health care service; however, only NP candidates are paid for their clinical placement hours. NP candidates and NP students are henceforth referred to as student NPs (SNPs).

Recruitment

Invitations to participate in this study were emailed upon registration for the professional symposium. All participants were provided with a copy of the participant information and consent form upon registration. Participants provided informed written consent before participation.

Reflexivity

Because some researchers were known to participants, an external researcher facilitated the focus groups and survey collection to minimize perceived power imbalances. Authors considered how their professional backgrounds, experiences, and prior assumptions affected data extraction and analysis. M.M. is a clinical nurse from a rural hospital and was (at time of data collection) a NP candidate. R.O. is an experienced NP in a regional hospital and a symposium organizer. W.M. is a rural health researcher with a background in education and physiology. P.M. is an occupational therapist and rural health researcher with expertise in using qualitative methods. M.M. approached data collection and analysis with the lens of a rural NP candidate, R.O. from the perspective of regional NP preceptor, and W.M. and P.M. approached these processes from an educator's perspective free of expectations of what NP education should resemble.

Data Collection and Analysis

Three separate focus groups were facilitated, one each for ENPs, NNPs, and SNPs. Focus group guides were used to facilitate the discussions (see Supplemental Materials 1, available online at http://www.npjournal.org). Focus groups were audio recorded and transcribed using Sonix (https://shopsonix.com/). Transcripts were manually checked for accuracy and deidentified. Line-by-line coding and thematic analysis and synthesis was performed using an established 6-step analytical process[12] and the NVivo 1.7.2 software package (QRS International). Initial codes were developed by one author to ensure congruity and comprehensiveness, further refined by a second author, and verified by all authors.

Trustworthiness

We ensure the trustworthiness of this research by demonstrating credibility, dependability, transferability, and confirmability.[13] To ensure credibility, we have provided sufficient detail regarding data collection and data analysis and included all data in our analysis. Two researchers engaged in the analysis process and participated in peer checking and ensured data conformability. Coding decisions were tracked, and regular discussions occurred during data analysis processes to ensure dependability. Transferability of findings to other settings was supported by our use of a professional symposium for recruitment purposes, yielding a participant pool covering a radius of >230 km from the district's only regional public hospital. We ensured objectivity through our declaration and discussion of biases, by remaining objective through the study process, and by taking a neutral stance when reflecting the participant's voice in the findings. Those of us known to participants recused ourselves from data collection. We acknowledged our different areas of expertise, subjective biases, methodological preferences, and world views as we worked throughout the study, thereby demonstrating reflexivity.[14]

Results

Overview

Twenty participants were recruited (Table). Focus group durations ranged from 42 to 54 minutes. Participants were mostly women, aged in their 40s, with >10 years of nursing experience.

Thematic Analysis

Thematic analysis generated 2 themes and 2 subthemes: pathway clarity (enrollment and unstructured education) and financial viability.

Pathway Clarity

Participants discussed their concerns and confusion regarding the pathway from nurse to NP. Subthemes explored participants' views on navigating enrollment, organizational expectations, unstructured on-site education, and their views on the endorsement and credentialing processes that follow the completion of their formal master's program.

Table
Participant Demographic information

Variable	Experienced Nurse Practitioners (n = 10)	Novice Nurse Practitioners (n = 5)	Student Nurse Practitioners (n = 5)
Sex			
Female	5	5	4
Male	5	0	1
Employment			
Regional	9	4	4
Rural	1	1	1
Age, years	45 ± 7 (36-63)	41 ± 9 (30-54)	40 ± 7 (32-51)
Nursing experience, years	25 ± 9 (11-46)	14 ± 5 (11-20)	19 ± 7 (10-30)
Nurse practitioner experience, years	7 ± 4 (0.5-12)	<1	0

Data are presented as number of participants or as mean ± SD (range).

1. Enrollment

Participants reflected on the onerous enrolment processes. For instance, university application processes requiring health services executive approvals and prearranged hospital-based support teams. University expectations often clashed with those of executive officers and support team members, at times creating a "feedback loop" (SNP1) impeding nurses attempting to enroll in an NP course.

Executive wouldn't sign off… they're like "well, who is your support team?"…the support team [said] "So you had executive approval?" …I need somebody to sign something so the next person will sign something. (SNP3

Students and experienced NPs suggested existing NP teams could identify high-quality nursing staff who could "transition" into NP education pathways (SNP3). This selection process would provide quality assurances for executives approving applications and provide applicants with NP guidance, thereby simplifying enrollment processes. Participants felt experienced NPs should provide targeted education for applicants and be involved in interview and credentialing processes to ensure applicants meet service needs.

[Current NPs] don't have a say in who is a candidate. We can see that [we can] mould this person because they've got huge potential… let's start [role-]modelling [to] them early, get them that exposure. (SNP3)

2. Unstructured education

Participants described being frustrated with the lack of structure provided for on-site education. Supervised clinical placement was described as "ad hoc" by 1 participant (ENP3), whereas 2 others said there was "no [educational] program [provided for them to deliver]" (ENP6, ENP3). ENPs explained how the lack of "clear curriculum or clear framework" in their own education left them with a "lack of confidence" and unanswered questions about their readiness for clinical practice (ENP3). Another stated, "I'm not exactly sure what I need to know to be a safe practitioner… in a rural setting" (SNP1). Preceptors experienced high supervision workload, which was exacerbated by limited paid preceptorship time, education program structure, and high clinical workload as barriers to providing SNP with education and supervision.

You'll end up staying back a couple of hours to try and catch up… because you've been teaching and mentoring the whole day… it's very enjoyable… but it is exhausting taking that on for two years. (ENP1)

ENPs also identified larger systemic issues affecting the education of prospective NPs. These issues included limited input from the Australian College of Nurse Practitioners into SNP education, knowledge, and skill requirements; the need for hospital and health services (HHS) to incorporate a mandatory NP "post grad year" (ENP1), "really good internship" (ENP4) or fellowship program, and limited NP resource sharing between HHS. The burden is on each HHS, workplace, and often upon individual NPs, to develop their own local framework to support student learning in the workplace.

We haven't been well organised as a profession… We have the College [Australian College of Nurse Practitioners (ACNP)]. It kind of struggles… to make an impact… we haven't got an emergency College… [Every hospital] develops their own frameworks for different things… Districts need to be talking. (ENP3)

Some comments from SNPs and NNPs paralleled education concerns raised by ENPs. For instance, there was consensus that a competencies list they could "tick off" was desirable to support their education and "give confidence" to potential employers (NNP1). Other comments related to niche or rural settings, such as challenges related to developing models of care and business cases to create new NP positions. Several participants reflected on countless personal hours spent writing models of care, business proposals, and collecting statistics and demographics to create an NP position with "no guarantee that I will get the role" (NNP4) that they worked to create.

It took… three years of me continually writing business cases, models of care… I'd written everything… [the job advertisement] went worldwide because [government employer] knew I was the only [NP in my clinical field] in Australia. (ENP1)

Students raised concerns about their lack of understanding around the endorsement process. Some felt they had "no idea how this process works" (SNP1), whereas others expressed their limited understanding of local credentialing processes.

After you get a job… in 12 months, you get your credentials? (SNP4)

I thought you had to be credentialed before you practice? (SNP3)

I think there's confusion about credentialing. (SNP1)

[After you] get your degree and your… endorsement and start working… you have to find a role… your own model of care… credential,… [there are] hidden bits and pieces which we haven't looked into before we start university. So we [are]… not aware of all this background work that needed to be done. (SNP2)

An emotive topic among students was the limited knowledge of NP educational requirements among preceptors and the students themselves. This posed a barrier to finding clinicians willing to join

their clinical support team and to receiving education from their preceptors. One student described an encounter while trying to form a clinical support team who was asked "What does your course require me to do as a clinical supervisor?" and they realized "oh… I don't know either" (SNP1). Other students found that medical officers "don't know what [to] expect" from NP supervision (SNP2), were unaware of the workload commitment or too time poor to volunteer as preceptors. (SNP4)

> *They [supervisors] don't know what… the expectation… from a student is… so I think they need to be educated… That's another barrier… nobody wants to be your supervisor. (SNP4)*

Another barrier to accessing education, particularly in rural hospitals, was a reluctance from some medical officers to support SNP education.

> *Some doctors… often say, "I don't have time to help you today" … And you're like, seriously? And then they come to you like, "I need you to do this, this and this." And you're like, "I'm an [NP candidate] today. I've got my own patients" … "I'm the doctor, you're the nurse, your title still has nurse written on it" … [some] doctors don't see the need for us. (NNP1).*

Financial Viability

All groups identified limited funded positions for SNP education as a barrier to NP course completion. Sometimes, unfunded SNPs made substantial life changes to pursue their education.

> *We sold our house, we've downsized. I've dropped my hours so that I can do the study because the candidate positions just don't seem to be there. (SNP3)*

Unfunded positions extended the time needed for master's study and negatively affected quality of life, mental health, and overall well-being.

> *It's very different for a candidate because they're… a funded role. I was an NP student. You are funding yourself and everything. You were using all your holidays to do your prac… You were taking leave without pay. (ENP1)*

It was suggested that funded SNP positions could be centrally managed to further streamline the education process.

> *There's no candidate position attached to [university places]… [there] should be. It would be nice if there were a central place where you applied… I think there's just that disjoint between [university and employer] funding. (ENP4)*

Discussion

This research explored the perspectives of nurses undertaking NP education and of NP preceptors. The main barriers to pursuing an NP career are that pathways to becoming an NP are unclear, onsite education that is unstructured or absent, and there is limited access to funded clinical placement positions. Clear organizational processes for NP selection, clinical support team formation, and approval of university enrollment was desired. Key enablers to pursuing an NP career include incorporation of an internship, postgraduate year, or fellowship program for new NPs, additional funded preceptor time, preceptor understanding of educational needs, and a greater leadership from the NP national college on matters relating to formalizing SNP education, mandating of clinical skills, competencies, and knowledge requirements similar to medical collages.

Some SNPs experienced financial barriers during their studies. Financial challenges, when combined with high tertiary study costs and the insecure employment opportunities, may represent a substantial barrier to nurses pursuing a career as an NP. This finding is consistent with the experiences of New Zealand NPs who report personal costs, arduous application processes, and a lack of guaranteed employment as barriers to becoming an NP.[6] Similarly, recommendations have made been in New Zealand to provide support—including consistent and appropriately funded supernumerary practice—to SNPs throughout their NP pathway.[15]

The Australian Nursing and Midwifery Accreditation Council defines the expectation of NP clinical capabilities through the Nurse Practitioner Accreditation Standards.[16] Standard 8 stipulates that SNP receive "…a range of health care experiences that supports knowledge and skills development in patient centered care that is consistent with the principles of primary health care and complements the student's specialty skills and knowledge."[16]

It has been noted within Australian policy research that the standard lacks any specific detail of the expected clinical skills, knowledge, and attributes to be attained, leaving substantial potential variation in the capabilities of future NPs.[4] This lack of specificity is reflected by participant frustration with unstructured SNP education and desire for deliverables such as a competency checklist. This overall call for consistency in education and better transparency around skills and competence is supported by earlier research recommending the removal of the specific number of advanced practice clinical placement hours required in favor of competency-based assessments and specific performance indicators.[4]

Changes at the local and district level should prioritize the development of consistent educational processes, clear goals and expectations, availability of educational opportunities, and provision of trained preceptors for all SNP. Such changes could reduce uncertainty for SNPs and their preceptors, while concurrently building SNP's knowledge, networks, and clinical skills. Ongoing education and professional support after graduation is also crucial for SNPs. For instance, internships benefit medical practitioners by providing supported roles, a safe opportunity to continue to learn, and a transition into practice—without the expectation to perform similar to senior clinicians.[17] Internships, fellowships, and mentorship programs provide similar benefit to early career NPs.[18-22] The programs can also support the development of credentialing and educational frameworks.[23] We note that some Australian states have clearer guidelines on NP development—with some providing NP coordinators to support NP and SNP educational needs, governance, and role development—potentially addressing some of the barriers identified by participants.[24]

Participants in this study emphasized that NP teams should stream capable nurses into NP pathways. This would support them to develop advanced clinical skills and build professional relationships with NPs and consultants, thereby supporting them to establish clinical support teams for master's course entry requirements. This streaming process and preexisting professional preceptorship relationships would provide assurances to executives signing off on enrolment applications. This recommendation parallels literature reporting that NP leaders support the transition of registered nurses to NPs, aid SNP progression and development, and facilitate communication between SNPs and executive staff.[14,25] Identifying individuals for NP streaming could occur during annual performance development assessments, through clinician recommendations, and use of the Australian Advanced

Practice Nursing Self-Appraisal (ADVANCE) tool.[26] Streamlining the enrollment process—for instance, by creating local or statewide policies outlining governance requirements similar to those in New South Wales[24]—may support those pursuing NP study. Local or statewide policies could also minimize "political agendas, turf wars, and professional hierarchies" that challenge Australian nurses seeking endorsement as NPs.[27]

Additional paid SNP positions, jointly managed by health care organizations and universities, would ease the financial and time burdens of NP study and limit bureaucratic delays. This change would reduce the need for SNPs to use leave or work additional hours to complete their studies, addressing a substantial barrier to course completion. Education, supervision quality, and supervision workload could improve by including preceptorship time within working hours and offering appropriate remuneration for work outside their standard roster.

Limitations

This study is potentially limited by sampling bias because participants were drawn only from participants at a professional symposium. However, this sampling method also ensured that participants were drawn from facilities across a wide geographic area encompassing rural and regional areas and public and private providers, increasing the generalizability of the findings.

Conclusion

This study explored the views of ENPs, NNPs, and SNPs on the barriers and enablers faced by nurses pursuing an NP career. The main perceived barriers to becoming an NP were lack of pathway clarity (particularly complex course enrollment processes), difficulty finding preceptors, a lack of structured education programs and on-site education, limited funded clinical education time for preceptors, and an insufficient supply of funded SNP positions. Perceived enablers included the clinical support team supporting SNPs, district health executives, NPs, and universities collaborating to streamline enrollment processes, structuring NP clinical placements, and identifying potential NPs early and tailoring their education towards an NP skill set. The development of formalized district or statewide education programs and clear knowledge and skill expectations should be established to ensure consistently high-quality NP graduates. The burden of NP education and graduate quality can be further improved with sufficient paid time for SNPs and preceptors and graduate transition into practice programs such as fellowships, internships, and postgraduate positions. Enhancing NP education for regional and rural nurses will strengthen the quality, capability, and confidence of new NPs and support higher-quality patient care, improved patient satisfaction, and a faster return on investment for health care organizations.

CRediT authorship contribution statement

Michaila MacAskill: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Randall Oliver:** Writing – review & editing, Validation, Resources, Conceptualization. **Priya Martin:** Writing – review & editing, Validation, Methodology, Conceptualization. **William MacAskill:** Writing – original draft, Validation, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

Declaration of competing interest

In compliance with standard ethical guidelines, the authors report no relationships with business or industry that may pose a conflict of interest.

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Data and Resource Availability

The data that support the findings of this study are available upon reasonable requests from the corresponding author.

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