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AMA submission on Nurse Practitioner 10 Year Plan Consultation Paper

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General comment

The AMA supports nurse practitioners (NPs) working collaboratively with GPs and other specialist medical practitioners as part of a team based approach to the provision of health care. While the AMA acknowledges that NPs can provide a valuable contribution to a multidisciplinary health care team, we do not support proposals for NPs' access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme (PBS) independent of a collaborative arrangement.

When MBS arrangements were extended to cover services provided by nurse practitioners the Government specifically included requirements for NPs to collaborate with doctors as a pre-requisite. It was acknowledged at the time that providing MBS funding for NPs operating as independent and alternative providers to medical practitioners would fragment patient care with the inherent risk to patient safety that this involves and increased overall health system costs attached to this.

While NPs are sometimes promoted as means to address workforce shortages and improve access to care, this is best achieved when they are part of a well-coordinated GP led model of care. With Australia having now decided to embrace the medical home, policy must be directed towards further strengthening General Practice and supporting GPs to collaborate with other health care professionals, like NPs, in circumstances where the care of the patient would benefit from this. Any policy direction that seeks to support NPs in carving out a more independent role in the health system is the antithesis of the move towards the medical home and the benefits to the health system that this will bring.

Scope of Practice

It is important to recognise that NPs, while highly skilled in specific areas, do not have the same depth and breadth of training as required to be a medical practitioner.

The AMA is concerned that a number of sweeping statements in the Consultation Paper fail to adequately reflect the limits of a NP's scope of practice. The advanced skills of NPs are generally limited to a specific field of care in which the NP has undertaken further training and education and, while these skills are extraordinarily valuable, they do not match the breadth of training and

experience of a GP. Only GPs are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern.

Other health professionals, such as NPs, may be able to make a limited diagnosis of a specific illness or injury, but they are not trained to make a differential diagnosis, nor assess or care for a patient as a whole person.

Prescribing

Only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. The AMA does not support independent prescribing by non-medical health practitioners outside a collaborative arrangement with a medical practitioner, and as such the current PBS requirements are appropriate. Prescribing by non-medical practitioners should only occur within a medically-delegated team environment in the interests of patient safety and quality of care. The AMA's 10 minimum standards for prescribing[1] outlines the minimum standards that must be required of all prescribers authorised to prescribe. The AMA supports the high standards required by the NPS MedicineWise Prescribing Competency Framework to safely prescribe independently.[2]

Australia's medicines policy currently has a focus on the Quality Use of Medicines, including deprescribing to reduce the harms and risks of polypharmacy. Promoting patient discussions about non-pharmacological solutions should be a priority rather than expanding the range of prescribers. Deprescribing can be complex and involves reviewing all medications and the patient's holistic health care, their goals and preferences. This is best led by the patient's usual GP in collaboration with a pharmacist. In comparison, an independent NP who has a limited scope of practice will not be able to prescribe in a holistic manner and may not know a patient's full medical history.

The AMA supports the national inter-governmental arrangements for the conferring of prescribing authorities on non-medical health practitioners which were endorsed by the Council of Australian Governments in 2016, proscribed under the National Law, described in Guidance for National Boards, and are administered by the Australian Health Practitioner Regulation Agency. This aims to ensure nationally consistent approaches to prescribing by non-medical health practitioners that are transparent, robust, and informed by evidence. They also ensure common standards across professions for training and clinical practice, and support the safe and effective use of prescription medicines. The AMA is concerned that the consultation paper does not recognise the need for a nationally consistent prescribing agreement for NPs through this process. Any expansion of non-medical practitioner prescribing should only occur within this framework.

[1] Australian Medical Association (2019) *AMA 10 minimum standards for prescribing*.
[2] NPS MedicineWise(2021) *Prescribing Competencies Framework–2nd edition.*

Currently, NPs are not required to have an endorsement of scheduled medicines,[3] however regulation varies considerably across jurisdictions. The AMA is particularly concerned that NP prescribing scope of practice can be self-defined in some jurisdictions.

To ensure patient safety and cost-effectiveness for the health care system, any expanded scopes of practice by non-medical health practitioners should be underpinned by a process that ensures:

- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished;
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs;
- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies; and
- there are documented protocols for collaboration with other health practitioners.

Collaborative Arrangements

The AMA notes that while there is evidence to support greater clinical autonomy for nurses, such research is undertaken in environments (i.e. hospitals) where there are established nurse-driven protocols which provide a path for the delegation of clinical authority[4] under a medical oversight framework.

Furthermore, the AMA notes Salisbury and Munro's review of nurse-led walk-in centres which highlights that while:

> "There is increasingly strong research evidence that nurses working in a general practice setting can safely and effectively manage minor illness. It is important to note that this evidence relates mainly to nurse practitioners who have received extended training in the assessment and management of minor illnesses, and who are working in an environment where they are closely supported by medical colleagues. It does not necessarily follow that nurses without nurse practitioner training and who work independently of doctors can provide a similar standard of care in a different environment."[5]

To avoid the fragmentation of patient care, particularly within primary health care, it is vital that the patient's usual GP is central to their care. GP care is the most accessible with almost 85 per cent of patients seeing a GP each year,[6] and over 95 per cent of patients attending the same

[3] Australian Health Ministers' Advisory Council (2016) *Guidance for National Boards: Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines under section 14 of the National Law.*

[4] Rao, Aditi D et al. "Better Nurse Autonomy Decreases the Odds of 30-Day Mortality and Failure to Rescue" *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* vol. 49,1 (2016): 73-79.

[5] Salisbury, C. and Munro, J. (2003) Walk-in centres in primary care: a review of the international literature. British Journal of General Practice, 53 (486). pp. 53-59. ISSN 0960-1643

[6] Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2018-19

general practice.[7] Recent reforms such as telehealth and ePrescribing have only increased patient accessibility to GP care. Care provided through general practice[8] contributes to:

- Lower all cause morbidity (lower rates of ill-health) and mortality;
- Lower rates of people being readmitted to hospital after treatment;
- Fewer consultations with consultant specialists;
- Less use of emergency services;[9] and
- Better detection of adverse effects of medication interventions.

Within the above, the AMA considers that NPs have a contribution to make to the quality and continuity of patient care within the primary care sector where they work in collaboration with medical practitioners, preferably within the confines of an integrated primary health care team working in a general practice medical home or where there is a formal collaborative agreement in place.

The consultation paper (p 5 and 11) mentions NPs collaborate with other health professionals and references the Nurse Practitioner Standards for Practice, yet the Standards themselves (2.4.1 and 2.4.2) do not indicate an expectation or requirement under the Standards for the NP to collaborate with a patient's usual GP or treating medical practitioner about their care.

The legislated requirement for collaborative arrangements ensures that NPs practising privately do not work in isolation from the medical profession.

Impact if collaborative arrangements removed

There is a real risk that a patient's usual doctor can be excluded from decisions about a patient's care or decisions are made in the absence of all necessary information.

Where care becomes fragmented in this way, it increases the risk of poor patient outcomes[10] due to misdiagnosis and missed diagnosis, delayed medical intervention and treatment, and adverse outcomes from the interaction of different medications and treatments. There will be more costs as a result of the duplication of services as well as the unnecessary requesting of imaging and pathology services and provision of needless referrals. The current collaborative arrangements model is designed to prevent this and ensure patients receive high quality care.

Enhancing NPs role within a collaborative environment

NPs working within a specialist medical practice, or a general practice which operates as a medical home for its patients, or an Aboriginal health service can help increase service capacity and support patient care. This is a supportive environment with strong clinical oversight that also allows them to work with clinical autonomy according to their skills and experience and

[7] Britt, H., et al. General practice activity in Australia 2015-16. General practice series no. 40. (2016)
[8] World Health Organization, The world health report 2008: Primary health care now more than ever, WHO, Geneva, 2008.
[9] O'Malley AS, *After-hours access to primary care practices linked to lower emergency department use and less unmet medical need*. Health Aff (Millwood), 2013. **32**(1): p.111
[10] Frandsen B, et al, Care fragmentation, quality, and costs among chronically ill patients, Am J Manag Care. 2015: 21(5):355-362.

appropriate clinical protocols. This is a safe and well coordinated model of care where care can quickly escalated to a medical practitioner when needed.

Similarly, other collaborative arrangements which involve either a medical practitioner referral, or a written collaborative agreement, establish the expectations of the working relationship between the two providers, ensuring the continuity and coordination of patient care.

A referral if accepted establishes a two-way communication between the referring doctor and the NP about the patient's care needs. When a GP initiates a referral they will provide information necessary to ensure the patient's continuity of care, and outline the purpose and expectations of the referral. For example, the furnishing of an opinion on the patient's condition/treatment, or regular update and review on treatment progress and patient outcomes.

A written collaborative agreement can cover one or more patients. It ensures all parties clearly understand and agree on their respective roles and obligations. The AMA believes any such collaborative agreement should specify the responsibilities and agreed scope of practice of the parties; the clinical settings in which care will be provided; and the protocols for initiating tests, prescribing, communicating and sharing information, and care collaboration or escalation.

The AMA does not consider an expansion of fee for service items as the best mechanism for medical practices or health services to utilise NPs in the care of patients. It would be more appropriate if practices were supported to employ NPs through better funding of the current Workforce Incentive Program, which when combined with existing NP items and a role for NPs in activities such as health assessments and the preparation of care plans would make their engagement more viable. For those NPs working outside of a medical practice, the current suite of MBS items remains appropriate, provided of course that these are linked to a collaborative arrangement with a medical practitioner.

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