AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA submission on Increasing access to health and aged care: a strategic plan for the nurse practitioner workforce (the Plan)

Email: nursepolicy@health.gov.au

The AMA is supportive of the aim of the Plan, that is to "support the ongoing development of a capable, resilient NP workforce delivering person-centred, evidence-based, compassionate care." Unfortunately this document lacks appropriate detail and structure to be considered a plan. There is significant lack of meaningful strategy that is required to build the NP workforce and better integrate it into the parts of the health system[1] that would most benefit from access to NPs. This is disappointing, as the AMA agrees with much of the content of the document, and indeed we are supportive of NPs and the value they add to Australia's health system.

The only real outcome we can see from this document is further attempts to expand access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), and to remove the requirement for an NP in a collaborative arrangement to do this. We have seen no evidence provided that this is safe, will lead to an increase in the NP workforce, or will improve the distribution of the NP workforce to areas of underservice.

The most likely outcomes are fragmentation of patient care and, as we have repeatedly raised, growth of corporate enterprises where medical practitioners are replaced by NPs. The growth of corporate after-hours service providers and the significant increase to health expenditure from the unprecedented surge in claims for MBS after-hours items, particularly urgent attendances,[2] when GPs responsibility for providing after hours care was diminished is an example of how this would occur.

As the AMA has noted in previous public consultations on the NP workforce, the continued attempts to position NPs as independent and alternative providers to medical practitioners is of significant concern. Australia does not require a new, siloed profession actively competing to treat a portion of a patient's health conditions, we require all healthcare professionals working collaboratively to address the specific issues they are trained to treat and manage coordinated through a general practitioner in a medical home model.

1 While the consultation paper talks about health and aged care systems, the AMA believes that aged care must be part of the health system to limit fragmentation and deliver better outcomes.
2 Jackson, C. Review of the After Hours Primary Health Care, Report to the Minister for Health and Minister for Sport. 31 October 2014.

The proposals in this document will not address issues of health care demand in Australia and will instead lead to increased health system costs, fragmentation of patient care, while undermining the safety and quality of the care that patients receive. This is not a substitute for more appropriately investing in general practice, a workforce of around 40,000 providing comprehensive primary care instead of attempting to solve accessibility issues with a significantly smaller workforce with less training and limited scope for providing care. This draft consultation document focuses on using the NP workforce to improve access to people living in regional, rural, and remote communities as well as Aboriginal and Torres Strait Islander communities. The AMA argues that these communities have the same rights as those in metropolitan areas to receive high quality medical care.

In terms of the NP workforce, we need to see genuine strategies to expand and incorporate the NP workforce into specific areas of the health and aged care systems. The advanced skills of NPs are generally limited to a specific field of care in which the NP has undertaken further training and education. A better plan would have identified these areas of advanced skills, mapping them to areas of need, and focused on how to incentivise those NPs with advanced skills to work where required, and how to encourage more nurses to pursue the advanced training.

For example, the AMA is very supportive of increasing the presence of NPs in aged care, but there is nothing in the plan that focuses on barriers preventing entry into the system, incentives to work in other areas such as hospital emergency departments, and what registered and enrolled nurses need as an incentive to pursue advanced skills in aged care and then to work in the sector.

The AMA does not support this plan. We have recommendations in this submission on areas that a revised plan should focus on.

Outcomes

> *Outcome 1: Consumers will have access to a range of services, including NP services, in all settings across the country.*

The AMA supports this outcome. This must be a key goal of our health and aged care settings. The AMA believes that NPs are a key part of this, but they are a small workforce of just over 2000. The AMA would suggest that this should more clearly state that consumers should have equal access to health and aged care services across the country. We do not support two-tiered systems where people living outside of metropolitan areas have non-medical care presented as an alternative due to issues of access.

> *Outcome 2: Consumers will be informed to choose appropriate NP services.*

The AMA is supportive of consumers fully understanding the training and experience of whichever healthcare provider is treating them in all environments. Increasing health literacy leads to improved health outcomes,[3] and a key component of health literacy is knowing how to engage with and navigate the health system. In most instances NP services are not the most

3 AMA (2021) *Health Literacy Position Statement*.

appropriate for a consumer seeking un-referred care. The AMA does not support Government advertising of specific NP services outside of advertising of all available health services which list the qualifications of practitioners.

> *Outcome 3: The health and aged care system will enable NPs to work to their full 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 statements in the draft that overstate the skill set of NPs. The advanced skills of NPs are generally limited to a specific field of care in which the NP has mastered, for example emergency care or diabetes management. It is only within their specific scope of practice that NPs can provide the breadth of care articulated in the following statement.

> "NPs have the skills, knowledge, expertise and legal authority to provide preventative care as well as diagnose and treat people of all ages with a variety of acute and chronic health conditions. NPs can provide prescriptions and access to Pharmaceutical Benefit Scheme (PBS) medicines, request and/or interpret diagnostic imaging and pathology tests and refer to medical and allied health specialists." (page 25).

The AMA noted this in the past submission, and it is disappointing this context has not been added as it would have benefited the Plan by focusing it on the specific advanced skills and where they are required across the health system.

One of the challenges for the NP workforce which is completely absent from the paper is the current lack of definition of NP scope (or scopes) of practice. Standardised NP domains with defined scopes would make credentialing easier. As it is the current system relies on individual, tailored credentialing. Addressing this would highlight skills and scope across the health system to facilitate NPs working in their areas of advanced skill.

Positioning NPs as generalists, and directly in competition to GPs as the '*Consumer satisfaction and health-related outcomes'* paragraph on page 2 does is not only unhelpful, it is inaccurate. 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 in the total health care of the whole person. They are trained in specific areas with specific levels of knowledge and experience and are not able to make a truly holistic assessment of the patient.

> *Outcome 4: The NP workforce will practice in a culturally safe way and reflect the diversity of the communities it serves.*

The AMA is supportive of all health practitioners practising in a culturally safe way and supports this as an outcome.

Theme for Action 1. Education and lifelong learning

The AMA is unclear how the outcomes attached will be brought about by this plan and has concerns with some of the statements.

The AMA supports increasing the representation of First Nations Australians in the NP workforce, and across the health workforce more broadly. This is the only component of this theme that has realistic and achievable goals.

However, the Plan fails to properly articulate how education will contribute to "aligning the supply of NPs with anticipated community need into the future". The plan itself never defines what this is, nor does it propose how it is intending to measure and map current or anticipated community need. This is fundamental to any workforce strategy and should have been completed ahead of this Plan.

Likewise, it is unclear why "expanding the range of NP services and improving access" is under the education action. More importantly, no justification has been provided for this. The AMA does not support the expansion of access to MBS items for NPs beyond those currently available, however should groups representing NPs seek to expand the range of services, the Medical Services Advisory Committee (MSAC) and MBS Review Advisory Committee (MRAC) processes are the established pathways for considering applications for new MBS items or the amendment of existing items. These processes ensure that proper consultation and consideration is given to new items. It is not the place of this Plan to make these statements, particularly when no there is no clinical area identified.

The AMA is also unclear on what value to the health system increasing access to the MBS and PBS would add. The paper has not outlined parameters for this expanded access nor provided a system-level value proposition to justify this. Australia has thorough safety and quality standards in health care, medicines scheduling and administration, but this paper has not acknowledged this or included any description of how the expansion of access would interact with these essential mechanisms that ensure patient safety and positive health outcomes. Noting the weakly defined scope of practice for NPs discussed in *Outcome 3*, we are particularly concerned that expanding the limited formulary that NPs can prescribe poses potential clinical risk to patients.

Theme for Action 2. Recruitment and retention

The AMA is supportive of incentives for healthcare professionals to work in areas of need. However, as noted earlier, workforce shortage is not a justification to allow health practitioners to work beyond their scope.

In the medical profession, rural generalist are GPs who have upskilled in specific additional skills to be able to provide broader clinical services in rural areas. This includes, but is not limited to, anaesthetics, obstetrics, and emergency care. The education and training in these areas of additional skill is not determined solely by the two GP Colleges, it is determined with the relevant Learned Colleges with training and supervision by experienced practitioners.

Outcomes like "increasing opportunities for NPs to take on roles in new locations and service areas" ignore the safety and quality standards in our health system and do not belong in this Plan.

The AMA does support the medium-term action to "Strengthen incentives to bolster NPs in multidisciplinary care, including targeted incentives in rural and remote areas." The AMA is very supportive of multidisciplinary care. The AMA has strongly supported the expansion of the Workforce Incentive Program (WIP), which supports general practices to operate more akin to medical homes.[4] Supporting more NPs to work in rural general practices in collaborative arrangements with could see a larger role for NPs in activities such as health assessments and the preparation of care plans with the oversight and collaboration with medical practitioners.

Theme for Action 3. Models of Care

The AMA has significant concerns with the actions and outcomes of this theme. The rationale notes that Australians should have access to "person-centred care" that is "integrated", yet actively seeks to set NPs up as a new layer in our health system outside of existing health infrastructure. It also very cynically uses the language of Closing the Gap to advocate to work beyond the scope of an NP in 3.1.4.

This Plan has failed to make the case and lay out appropriate justification for expanding the scope of NPs and for the removal of collaborative arrangements.

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.

In terms of 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

4 AMA (2021) *Medical Home Position Statement*.

quality of care. The AMA's 10 minimum standards for prescribing [5] 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.[6]

Theme for Action 4. Health workforce planning

The AMA has actively called for improved health workforce planning for years, with the 2018 AMA Medical Workforce and Training Summit leading to the establishment of the National Medical Workforce Strategy.[7] Mapping the entire health workforce, surpluses and shortages as well as expected demand is essential for ensuring our health system is able to manage demand and continue delivering high quality care into the future.

This Plan does not offer any of this, instead using this section to promote awareness of NPs to consumers and build an evidence base ten years after changes have been made. There is no mention of the broader nursing workforce, the specific areas that NPs should be working in or the impact on those sectors. The whole plan seems to focus on NPs working independently, not collaboratively or in an integrated way.

The title of the plan itself includes aged care, yet the workforce planning section has no planning for better understanding demand or capacity, only promotion of awareness of NPs. This is a significant flaw and evidence of the failings of this document as a genuine plan.

General Comment

The AMA is supportive of an increased role for NPs in Australia's health system in collaborative, medically led models. We do not see how this plan delivers on strategies to achieve anything other than establishing NPs as a less qualified alternative to GPs in underserved communities. We also do not believe this would be a significant attraction for nurses considering becoming an NP.

NPs have an important role to play in Australia's health system, however the blurring of professional responsibilities and persistent attempts to expand scope of practice despite that lack of consistency and standards across the system provide ongoing challenges.

The consultation draft notes on page 24 that "NPs and participating midwives are the only health professionals legally mandated to establish a collaborative arrangement in order to access the MBS and PBS." The language again implies that this is a fundamental problem that must be removed and does not consider the positives of collaborative arrangements. The statement is also misleading.

The MBS, while not using the term "collaborative arrangements" other than with respect to NPs and midwives is in many respects structured around requirements that effectively mandate collaboration between health professionals. MBS funded specialist (non-GP) services require a

5 Australian Medical Association (2019) *AMA 10 minimum standards for prescribing*.
6 NPS MedicineWise (2021) *Prescribing Competencies Framework–2nd edition.*
7 AMA (2018) *Medical Workforce and Training Summit*.

referral while team care arrangements are also structured to require collaboration, with MBS funding for associated allied health services are clearly dependent on this.

The AMA sees collaborative arrangements with NPs and midwives as a positive model to emulate for other health professions seeking to establish advanced clinical roles. Collaborative arrangements provide essential quality and safety protections while promoting collaboration in health care, not fragmentation and competition.

The AMA is supportive of reforms and improvements to collaborative arrangements which could enhance an NPs role. This should occur in a team-based environment, for example NPs working within a specialist medical practice, a general practice which operates as a medical home for its patients, or an Aboriginal health service have significant potential to enhance service capacity and to support patient care. A structured model within this framework would provide clinical oversight of NPS, while supporting the delegation of specific services in which the NP is skilled. The collaboration with the medical practitioners within the practice would ensure the safety and quality of patient care, while NPs are supported to be responsible for more care. The scope of practice for this role is defined by the NP's specific skills and training, and care provision protocols, particularly for when an issue needs to be escalated with a medical practitioner.

The AMA remains open to working on the development and implementation of such models.

FEBRUARY 2023