

27/10/2023

Minister for Health and Aged Care, the Hon Mark Butler MP
Lead Reviewer
Australian Department of Health

To whom this may concern,

Thank you for the opportunity to submit a combined response from a number of the Peak Nursing Organisations in Australia, highlighting shared issues and advice, and providing a sense of how these key nursing organisations wish to see the work move forward. We greatly appreciate the extension to submit a response by October 30th 2023. The organisations represented in this combined submission are as follows:

- The Australian College of Mental Health Nurses (ACMHN)
- The Australian College of Nursing (ACN)
- The Australian College of Nurse Practitioners (ACNP)
- The Australian Nursing and Midwifery Federation (ANMF)
- The Australian Primary Health Nurses Association (APNA)
- The Council of Deans of Nursing and Midwifery (Australia and New Zealand)

This grouping represents nurses and midwives working in the public and private health sectors and across education, management, research and policy as well as clinical care in across the lifespan, including aged care and disability care, across a wide variety of urban, rural and remote locations. It includes those working in nursing support and enrolled nurse roles right through to nurses working in highly specialised clinical roles such as credentialled mental health nurses and nurse practitioners. In addition, it represents all those providing tertiary education to nurses and midwives in Australia. There are well over 320,000 nurses and midwives represented by these combined groups.

To set the scene, data from the NMBA shows that in 2023, 440,110 nurses in Australia held general registration. This comprised of 68,573 ENs, 360,108 RNs and 11,429 with dual registration. In June 2023 there were a total of 25,645 midwives, including 25,437 registered as RN/midwife, 105 registered as EN/midwife and 103 practitioners registered as EN/RN/midwife. Additionally, there were 7,410 midwives with single registration. 5 These figures demonstrate nursing and midwifery to be the largest workforce in the country. However, it must be noted that many nurses and midwives are not currently in the workforce. In October 2022, although 448,129 nurses and midwives were registered, only 372,759 were currently employed. Furthermore, we know that between December 2019 and December 2022, the number of nurses on the non-practising register doubled.¹ We also know that in June 2023 there was 2,656 NPs in Australia. However, 539 of them were not working as nurse practitioners.² For the ACMHN there are 25,000 mental health nurses (MHN) with 1,400 Credentialed Mental Health Nurses (CMHN) 405 of these are not working as CMHN or have left nursing for management roles. Reports from NPs in a number of our organisations suggest this is because NP

¹ Nursing and Midwifery Board of Australia (2023). "Nurse and Midwife Registration Data Table - 30 June 2023." Retrieved 19 October, 2023, from <https://www.nursingmidwiferyboard.gov.au/about/statistics.aspx>.

² Australian Government Department of Health and Aged Care (2022). "Fact Sheet Selector Dashboard. Nurses and Midwives." Retrieved 26 September, 2023, from <https://hwd.health.gov.au/nrmw-dashboards/index.html>.

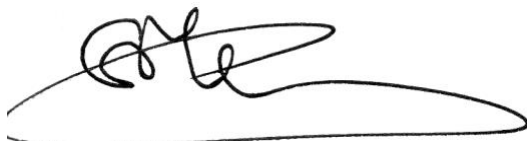
positions did not exist, highlighting a major lost opportunity. Members also report the lack of career progression available to NPs, resulted in a number moving to managerial positions where they can progress professionally and access higher remuneration.

1,089 midwives in Australia, held scheduled medicines endorsement.³ These figures represent a huge workforce with the potential to transform primary healthcare access and delivery if they are only able to work to full scope.

A recurrent thread running through all the submissions was the need for the emphasis in this scope of practice review to be on patient/consumer centred care. The government must prioritise patient access to the best care from all healthcare providers, rather than the traditional and all too frequent outcome of recent reviews of protecting the doctors' existing interests (for example, the MBS Review Taskforce, which in 2019 rejected all 14 evidence-based recommendations of its own Nurse Practitioner Reference Group).

I am grateful for the opportunity to provide this combined response and thank you for the extension on the submission.

Yours faithfully



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³ Nursing and Midwifery Board of Australia (2023). "Nurse and Midwife Registration Data Table - 30 June 2023." Retrieved 19 October, 2023, from <https://www.nursingmidwiferyboard.gov.au/about/statistics.aspx>

Q 3. Who can benefit from health professionals working to their full scope of practice?

Firstly, may we say that the need to review the ability for nurses and midwives to work to full scope of practice is warmly welcomed, as this has been a longstanding concern of the nursing and midwifery professions. In relation to the question who will benefit from health professionals in general, but specifically for this submission, nurses and midwives, it is our jointly held view that all the public and patients would benefit, as would all health professionals (even those who might oppose it initially) because it would free up all health professionals to gain role satisfaction by practising to their highest prepared educational and skill level. In addition to the public and the professionals, funders, employers and governments will benefit, by having a health professional who is educated and competent to deliver the care required in the right place at the right time, which will undoubtedly be both time and cost effective.

Q.4. How can these groups benefit? Please provide references and links to any literature or other evidence

The individual submissions from the above groups provide numerous examples of the outcomes for patients and women when nurses and midwives are able to work to full scope. A few of these are set out here.

- Liu, C. F., et al. (2020). "Outcomes of primary care delivery by nurse practitioners: Utilisation, cost, and quality of care." *Health services research* 55(2): 178-189.
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- Hewitt L, Dadich A, Hartz DL, Dahlen HG. Midwife-centred management: a qualitative study of midwifery group practice management and leadership in Australia. *BMC Health Services Research*. 2022 Sep 26;22(1):1203.
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- Traczynski, J. and V. Udalova (2018). "Nurse practitioner independence, health care utilisation, and health outcomes." *Journal of Health Economics* 58: 90-109.
- Queensland Health (2022). *Emergency Nursing. Improving access to care. Vision, solution, opportunity.* Queensland
- ACT Government ACT Health (2022). *ACT Public Health Services Quarterly Performance Report.* Canberra, ACT Health. July-September 2022.
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- Tracy, S. K., et al. (2014). "Caseload midwifery compared to standard or private obstetric care for first time mothers in a public teaching hospital in Australia: a cross-sectional study of cost and birth outcomes." *BMC Pregnancy and Childbirth* 14(1): 1-9.
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- Roche, M. A., et al. (2018). "Nurse-led primary health care for homeless men: A multi-methods descriptive study." *International Nursing Review* 65(3): 392-399.

- APNA Nurse Clinics <https://nurseclinics.apna.asn.au/what-are-nurse-clinics/>
- Howe, S. (2016). Nursing in Primary Health Care (NiPHC) Program – Enhanced Nurse Clinics: A review of Australian and International models of nurse clinics in primary health care settings. <https://www.apna.asn.au/docs/f221e342-13f3-e611-80d2-005056be66b1/Review%20of%20Australian%20and%20international%20models%20of%20nurse20clinics.pdf>
- Howe, S. (2016). Nursing in Primary Health Care (NiPHC) Program – Enhanced Nurse Clinics: A review of Australian and International models of nurse clinics in primary health care settings.
- Marion Eckert, Claire M Rickard, Deborah Forsythe, Kathleen Baird, Judith Finn, Andrea Gilkison, Richard Gray, Caroline SE Homer, Sandy Middleton, Stephen Neville, Lisa Whitehead, Greg R Sharplin and Samantha Keogh 'Harnessing the nursing and midwifery workforce to boost Australia's clinical research impact' *Med J Aust* 2022; 217 (10): 514-516. || doi: 10.5694/mja2.51758 Published online: 7 November 2022 <https://www.mja.com.au/journal/2022/217/10/harnessing-nursing-and-midwifery-workforce-boost-australiasclinical-research>
- HMA (2012), Evaluation of the Mental Health Nurse Incentive Program, Final Report. Department of Health and Ageing. Available at <http://www.acmhn.org/career-resources/mhnip/mhnip-review>
- Delaney, K.R., Naegle, M.A., Valentine, N.M., Antai-Otong, D., Groh, C.J. and Brennaman, L. (2017). The Effective Use of Psychiatric Mental Health Nurses in Integrated Care: Policy Implications for Increasing Quality and Access to Care, *Journal of Behavioral Health Services & Research*, pp 300–309. DOI 10.1007/s11414-017- 9555-x
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5. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own experience.

It is an odd sequence of questions to move straight from the question of who might benefit to a question related to risks and challenges. Given that the aim of the work is to “unleash potential” and that one strategy for doing so is to “enable health practitioners to work to full scope of practice”, surely a more positive approach would be to examine facilitators and barriers to begin with, then once those factors are identified, to explore whether there actually were any risks (although undoubtedly there may be challenges)? Beginning with a risk-based approach suggests a sense of hesitancy, rather than a sense of embracing opportunity.

Notwithstanding this observation, the overarching view from the submissions was that “the risks ... of enabling nurses to work to their full scope of practice are low” (ACN response). In terms of challenges, issues relating to educational pathways and support for ongoing education in terms of both scholarships and study leave were identified. Another challenge was the need for transferable recognition of clinical skills and education (howsoever described). The ACN provided a number of firsthand accounts by members of delays to care and lack of access to care due to a nurse who was trained and accredited in one organisation to perform a skill being unable to do so in their next place of employment.

This eloquent excerpt from the APNA submission identifies the essence of the issue relating to risk here. (The references from this excerpt have been removed but are available in the APNA submission).

The ‘risk’ of enabling nurses to work to their full or expanded scope of practice appears to have gained momentum from historical and antiquated notions of what nurses do and concerns held by other health practitioners that nurses may be impeding on their clinical ‘turf’. This has been expressed in some publications and has the potential to create professional tensions between PHC nurses and medical professionals specifically. This problem appears to be more overt in general practice settings where Medicare descriptors can be viewed as a proxy for governing clinical practice.

Furthermore, for decades, doctors in general practice have been doing work that would be traditionally done by nurses in many other sectors, either because of a lack of availability of a nurse in their team and/or because only the doctor is funded for the care activity. This gatekeeping by other health practitioners constrains collaboration and multidisciplinary care needed to address the health needs of our ageing population and the increasingly complex needs of Australians generally.

Furthermore, it builds siloes and barriers that not only detrimentally affect patient care, but unfairly place restrictions on nurses’ scope of practice, as is experienced particularly by many Nurse Practitioners in Australia who have had their employment limited due to resistance from medical professionals. From APNA’s perspective, the risks for not letting PHC nurses work to their full and extended scope of practice when needed (as regulated, legislated and educated to do so), as detailed in this submission, are:

- Under-utilisation of nurses and inefficiency in health service delivery
- reduced patient access to health services, including prevention, screening and management of chronic diseases
- Lower recruitment and retention of nurses in primary health care, which is profound given PHC nurses are the largest workforce in primary care

And this equally persuasive argument from ANMF:

The greatest risk to primary healthcare and community access will be that everything stays the same, and profit-based models of primary healthcare, controlled by medical practitioners and other private providers, prevail as the accepted norm. Such models will result in increased government spending to support private business models with increased out-of-pocket costs for people seeking health care. Additionally, vulnerable, and high-risk groups may choose not to seek primary care, such as those experiencing homelessness, as mentioned earlier, resulting in increased presentations to the ED or use of other emergency services, such as Ambulance, due to health deterioration from a lack of assessment, monitoring and early intervention. Further, the constraints placed on the scopes of practice of nurses and midwives may result in increasing attrition rates, adding to workforce shortages and further limiting access to primary healthcare.

7. Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

Examples have already been provided in the impact section in Q.3, but below are a number of others from ACN's submission. ANMF's submission and APNA's submission also provide numerous examples.

Asthma management in the Mackay, QLD region - [Breathe Easy, Breathe Safe Project](#)

Improving the health of prisoners in Trawalla, north of Ballarat, Victoria - [Healthy Ageing Clinic in a Prison Service](#)

Providing health checks for Aboriginal and Torres Strait Islander community in Mackay - [Aboriginal and Torres Strait Islander Health Clinic](#)

Improving health outcomes for patients managing chronic heart failure in a community setting and improving access to resources and information for primary care nurses, WA – [Chronic Heart Failure Nurse Clinic Project](#)

Preventative health nurse clinics (PHNC) were established as the primary means to facilitate chronic disease risk screening in the practice population using the My Health Check Tool (MHCT). The nurse-led multi-disease risk screening was established in 4 general practices in Western Victoria - [Preventative Health Risk Screening and Nurse Health Coaching.](#)

APNA (n.d) [Nurse clinics – A welcome change.](#)

Bonner, A., Havas, K., Tam, V., Stone, C., Abel, J., Barnes, M., Douglas, C. (2019) An integrated chronic disease nurse practitioner clinic: Service model description and patient profile. *Collegian*, 26(2), pp. 227-234.

Jennings, N., Gardner, G., O'Reilly, G., Mitra, B. (2015) Evaluating emergency nurse practitioner service effectiveness on achieving timely analgesia: a pragmatic randomised controlled trial. *Acad Emerg Med*. 22(6):676-84.

Dadswell, C., Atkinson, D. & Mullarkey, A. (2017). Impact on demand following the launch and closure of NHS walk-in centres. *British Journal of Healthcare Management*. 23 (11)
<https://doi.org/10.12968/bjhc.2017.23.11.539>

Desborough, J., Forrest, L., & Parker, R. (2013). Nurse satisfaction with working in a nurse-led primary care walk-in centre: an Australian experience. *Australian Journal of Advanced Nursing*, 31(1), 11-19.

Gardner, G., Gardner, A., O'Connell, J. (2014) Using the Donabedian framework to examine the quality and safety of nursing service innovation. *Journal of Clinical Nursing* 23(1-2):145-55.

Howe, S. 2016. [Nursing in Primary Health Care \(NiPHC\) Program – Enhanced Nurse Clinics: A review of Australian and international models of nurse clinics in primary health care settings.](#)

Stephen, C., et al. (2018). Feasibility and acceptability of a nurse-led hypertension management intervention in general practice. *Collegian*, 25(1), 33-38.

Stephen, C., et al. (2018). The feasibility and acceptability of nurse-led chronic disease management interventions in primary care: an integrative review. *Journal of Advanced Nursing*, 74, 279-288.

Stephen, C. et al. (2022). Nurse-led interventions to manage hypertension in general practice: A systematic review and meta-analysis. *Journal of Advanced Nursing*, 78(5), 1281-1293.

Zwar, N., et al. (2022). Giving asthma support to patients (GASP) program evaluation. *Australian Journal of General Practice* 51(4), 257-261.

Zwar, N., et al. (2017). Improving blood pressure control in general practice: Quantitative evaluation of the ImPress intervention. *Australian Family Physician*, 46(5), 306-311.

Zwar, N., et al. (2010). Quit in General Practice: a cluster randomised trial of enhanced in-practice support for smoking cessation. *BMC Family Practice*, 11, 59.

Halcomb, E. J., et al. (2019). Nurse-delivered interventions for mental health in primary care: A systematic review of randomised controlled trials. *Family Practice*, 36(1), 64-71.

9. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

The individual submissions provide numerous suggestions for barriers to be addressed, some of which are specific to their workforce and the references to these are within the original submissions. However, these can be consolidated as follows:

Barrier 1: Financial constraints impacting models of care (see suggestions in enablers in relation to this also)

The current funding restraints in accessing the MBS and PBS by nurses and midwives impact their ability to work to their full scope of practice in the community. Enabling healthcare practitioners to have full access to MBS items, which allows patients to choose their healthcare provider freely and clinicians to work to their optimal scope, including diagnostics and referrals. There is a need to ensure that NPs have access to adequate funding, and can fully participate in incentive programs, and accreditation of practices. There is also a need to ensure fair and equitable remuneration for

specialist nurses (such as mental health nurses), midwives and nurse practitioners, considering their expertise and responsibilities.

Barrier 2: Perceptions and attitudes held by others about nurses' roles

ACNP makes the following point about policy and stigma: there is a need for policy changes across many settings, including aged care and acute care settings to allow healthcare professionals, including NPs, to offer their full range of services. These changes will remove the stigma and cultural biases between different healthcare providers, such as GPs and acute care practitioners, and result in enhanced collaboration.

There is a real need to invest in education for the general public with an awareness and education campaign that increases public awareness and understanding of what nurses, midwives and nurse practitioners can offer in healthcare. Educating other healthcare professionals and the public about the capabilities and contributions of these groups is critical to the success of “unleashing the potential” for all health practitioners.

The CDNM were also concerned about education in general and recommended the promotion of multidisciplinary education that aligns with the scope of practice for healthcare providers as a means of improving understanding of each other's roles.

Barrier 3: Regulations and legislation inconsistencies between States and Territories/ Removal of jurisdictional and organisational boundaries

ANMF makes the point that identifying ways to remove jurisdictional and organisational barriers that limit the scope of practice of nurses and midwives is essential. Advanced practice roles provide alternatives to improve care by increasing the number of primary healthcare providers, especially where there is increased demand for services. Supporting nurses and midwives to work to the full scope of their education is often constrained by culture, education, regulatory issues, institutional issues, and professional practice boundary issues and should be addressed.

Medication regulations provide a good example of that. For NPs under s.95 of the Health Practitioner Regulation National Law 2009 (Qld), NPs are endorsed to prescribe, with the NMBA requiring that to be within their scope of practice. However, the jurisdictional constraints are often far greater.

ACNP observes that there is a need to harmonise legislation across states and territories to allow NPs to work more freely and consistently. Examples include the current lack of consistency across states for nurse practitioners to work with Motor Vehicle Insurance patients, Workers Compensation issues as well as specific clinical issues bound by state legislation such as prescribing for termination of pregnancy and signing of death certificates. Federally, significant barriers include limited access for patients of NPs to PBS and MBS subsidies, and care for veterans under DVA. More broadly, there is poor recognition of the diagnostic capacity of the NP, a key example being exclusion of NPs from the Autism guidelines, leading to extensive delays to diagnosis, treatment and support for people living with ASD.

Q 10. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

The extensive list below from the ANMF is inclusive of the shared views of the other organisations. The references are contained in the original submissions.

Funding reform. Move away from subsidised fee-for-service models that have resulted in the privatisation of primary healthcare. Move toward block and blended funding and employment models which support nurse-led care, such as the ACT Walk in Clinics, which are based on the provision of quality, affordable and accessible healthcare for all, not profit creation.

Fund midwifery group practices and midwife-led continuity models of care. This funding will improve health outcomes for women and their babies and decrease costs to the health system.

Increase primary healthcare theory, simulation and workplace learning in pre-registration nursing and midwifery education programs. Australia must focus on developing and expanding the capacity to deliver primary healthcare and educating the workforce to support it. Primary healthcare must be viewed and supported by more than just general practitioners and include areas such as mental health services, palliative care, women's and sexual health, wound care, diabetes care, health promotion, vaccination, school nursing and so on. Meeting the future workforce requirements of the primary healthcare sector must continue to be considered, including pre-registration education for nurses and midwives. Education providers should consider increasing the content and variety of primary healthcare theory, simulation and quality workplace learning experiences. Students should be exposed to the broad context of primary healthcare in the community through quality and supported practicum.

Resource provision for evaluation and planning of nurse and midwife-led services. Resource provision and funding are major barriers to the sustainability of nurse and midwife-led services. Often, this relates to a need for more knowledge or time to plan, collect, analyse, and interpret data to demonstrate outcomes of services and inform funding applications. This situation could be addressed in 2 ways.

- Providing resources to assist nurses and midwives in evaluating, planning, collecting, analysing, interpreting, and reporting on service data to support funding applications.
- Encouraging nurses and midwives to expand their scopes of practice into digital health, informatics and research through scholarships and the creation of nurse analysts and researcher positions in the primary care setting. This investment would add to the quality improvement of programs.

Encourage interdisciplinary learning. Governments, healthcare providers and educators should encourage and facilitate interdisciplinary learning and understanding of nurses' and midwives' (and other members of the MDT) scopes of practice. This education should extend to those who are not health practitioners but who have administrative, managerial or workforce planning responsibilities relating to nurses and midwives. This learning will help to prevent policies that restrict the scope of practice.

A cultural system change is needed to ensure that ENs are more effectively utilised, including initiatives to educate healthcare staff and employers on the scope of practice of EN's. These educational initiatives can result in an application of knowledge by the multidisciplinary team and employers to allow ENs to practice to their professional potential. Allowing ENs to work to their full capability based on their training will increase workforce productivity and advance their nursing roles.

Support ongoing education and professional development for primary health care nurses and midwives.

Nurses and midwives should be supported to undertake continuing education and professional development, including but not restricted to programs leading to NP and transitions to specialty practice in primary healthcare. Scholarships for nurses and midwives working in primary health care should continue to be supported and awarded.

Remove the necessity for collaborative arrangements for NPs and EMs. The ANMF welcomes moves to remove collaborative arrangements for NPs and supports the same for EMs.

Fund increased numbers of NP positions in primary healthcare, including home-based, community care and those working across services, i.e., outreach and in reach. For aged care, having more NPs would greatly reduce ED admissions, ambulance costs and hospitalisations. In rural and regional areas, NPs and APNs make access to health care more accessible and allow more services to be provided to Aboriginal and Torres Strait Islander populations.

Remove funding barriers for NPs. To work to their full scope of practice, NPs and EMs require access to the MBS and PBS, and incentives for bulk billing equivalent to medical practitioners who work in primary healthcare. The ANMF recommends revisiting and implementing the recommendations made to the MBS Taskforce by the Nurse Practitioner Reference Group (NPRG). The NPRG presented 14 recommendations for funding services that NPs already provide. None of the recommendations or the three alternative recommendations were accepted, demonstrating a lack of understanding or knowledge about the role of NPs by those on the MBS Taskforce. The decisions made by the MBS Taskforce not only rejected all recommendations of the NPRG but sought to impose additional restrictions on services provided by NPs. None of the MBS Taskforce additional restrictions were evidence-based.

This submission has been endorsed and approved by:

The Australian College of Mental Health Nurses (ACMHN) – Adrian Armitage - CEO

The Australian College of Nurses (ACN) – Karen Grace – National Director – Prof. Practice (acting)

The Australian College of Nurse Practitioners (ACNP) – Leanne Boase - CEO

The Australian Nursing and Midwifery Federation (ANMF) – Annie Butler - Federal Secretary

The Australian Primary Health Nurses Association (APNA) – Karen Booth - President

The Council of Deans of Nursing and Midwifery (Australia and New Zealand) – Karen Strickland - Chair