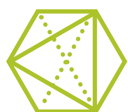

Australian College of Nursing

Reimagining the community and primary health care system

A WHITE PAPER BY ACN 2021

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ACRONYMS

ACCHS	Aboriginal and Torres Strait Islander Community Controlled Health Services
ACN	Australian College of Nursing
AHP	Aboriginal health practitioners
AHPRA	Australian Health Practitioner Regulation Agency
APN	Advanced practice nursing/ nurses’
APNA	Australian Primary Health Care Nurses Association
APPG	All-Party Parliamentary Group on Global Health
CALD	Culturally and linguistically diverse
C&PHC	Community and primary health care
CHN	Community health nurse
CHSP	Commonwealth Home Support Program
COAG	Council of Australian Governments
COVID-19	Coronavirus disease 2019 strain of SARS-CoV-2 severe acute respiratory syndrome coronavirus 2
CPD	Continuing professional development
DVA	Department of Veterans’ Affairs
EAG	Expert Advisory Group
EN	Enrolled nurse
GP	General practitioner
GPN	General practice nurse
GPRIP	General Practice Rural Incentives Program
HHS	Hospital health services
ISO	International Organisation for Standardisation
IPC	Infection prevention and control
IPCS	Integrated person-centred care systems
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex and asexual
MBS	Medicare Benefits Schedule
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NiTC	Nursing in the community
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse practitioner
PBS	Pharmaceutical Benefits Scheme
PNIP	Practice Nurse Incentive Program
PHN	Primary Health Network
RACF	Residential aged care facility
RAN	Remote area nurse
RN	Registered nurse
RWA	Rural Workforce Agency
VBHC	Value-based health care
VPE	Voluntary patient enrolment
WHO	World Health Organization
WIP	Workforce Incentive Program

EXECUTIVE SUMMARY

Nurses can influence a health care system that delivers evidence-based, person-centred care and optimal health outcomes, while providing the best value for money. Australia is the envy of the world, with all the components of a universal health system. However, nurses require greater support to leverage their skills, knowledge and expertise to deliver the health system Australia needs now and into the future.

The Australian College of Nursing (ACN) proposes a system redesign in community and primary health care (C&PHC) nursing to ensure a sustainable health care system for all Australians into the future. C&PHC nursing applies a social model of health care that addresses the health needs of individuals and communities while considering the social, economic and environmental factors impacting their health (Australian College of Nursing, 2018). This person-centred focus is attributed to all areas of nursing practice and provides an essential process of collaboration and partnership that takes place in the successful planning and delivery of care outside of the acute health care setting.

This white paper outlines the existing roles and responsibilities of C&PHC nurses, the current enablers and barriers to a more holistic, integrated, person-centred and value-based primary health care system, and provides key recommendations around the future of C&PHC nursing.

The C&PHC sector is a significant component of Australia's health care system, providing primary health care services to the community across the lifespan. This includes health promotion; the prevention, diagnosis and treatment of acute and chronic health conditions; and support in managing long-term health care, particularly for individuals with chronic health conditions such as diabetes, chronic obstructive pulmonary disease, cardiovascular disease and mental illness. In this sector, individuals regularly receive advice and health checks from primary health care providers including general practitioners (GPs), nurses and pharmacists (Victoria State Government, 2015). Evidence demonstrates that:

> *"those health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality. Nursing (and the wider health care system) in Australia must evolve, adapt and innovate in order to continue to provide effective patient care amidst ever increasing demand, emerging technologies and limited resources."* (Health Workforce Australia, 2014)

It is important to acknowledge that older Australians represent a significant proportion of those who receive C&PHC in the home or in community-based settings such as general practices, private practices, community health, and within local government and non-government service settings (for example, Aboriginal Community Controlled Health Services) (Health Workforce Australia, 2014).

Senior Australians benefit tremendously from community-based aged care, supporting their continued independence in the community and assisting older, frail individuals to remain in their homes for longer (Australian Institute of Health and Welfare, 2018a). However, at the same time, young families and middle-aged people benefit from community-based services that support health promotion, preventive activities and timely health care across the lifespan.

While Australia's health care system is performing well, it faces mounting challenges, particularly inequity of access to care, an ageing population, and a rise in chronic disease, along with workforce sustainability concerns for the nursing profession (Halcomb & Bird, 2020a). One of the main challenges is fragmented care with poorly coordinated care pathways between the primary health care sector and the acute sector, and poor flow of patient data. In Australia, less than 20% of GPs are informed of emergency department visits for their patients (Productivity Commission, 2017). In addition, many in Australia are uniquely disadvantaged and at greater risk of poor health outcomes, including Aboriginal and Torres Strait Islander peoples, those from culturally and linguistically diverse (CALD) backgrounds, those in the LGBTQIA+ community and those with poor health literacy and limited financial resources. These disadvantages have become even more stark in the wake of the COVID-19 global pandemic and 2019-2020 Australian bushfires, which have greatly impacted access to health services and vital therapeutic interventions. Technology is also changing the expectations and preferences of Australians around care and access to services; such innovations must be embraced in future reform of the C&PHC system.

We also must address inadequacies nurses face across the sector, in particular Veterans' Affairs and the National Disability Insurance Scheme (NDIS). Without adequate resources, nursing will continue to be under-recognised and under-valued in the C&PHC sector. These challenges can be addressed through a better understanding of the unique and diverse nursing roles within primary care; more effective use of C&PHC nurses; and appropriate remuneration of this skilled and highly valuable workforce (Halcomb & Ashley, 2019; Halcomb, Ashley et al., 2018). ACN believes this can be achieved through integrated person-centred care systems (IPCSs) which has been a policy objective in all Australian jurisdictions since a Council of Australian Governments (COAG) agreement in 1995 (Productivity Commission, 2017). This has also been addressed in the ***World Health Organization (WHO) Global Strategy on People-Centred and Integrated Health Services 2016-2026*** (World Health Organization, 2015), which has offered a pathway for a paradigm shift in the way primary health care services are funded, managed and delivered.

ACN also believes it is time the Australian Government embraces new models of care to ensure the C&PHC system works effectively and remains financially viable. Past experiences demonstrate that basic government funding increases without system-wide reforms do not translate to sustainable health and aged care systems (Global Access Partners, 2019; World Health Organization, 2015). ACN believes that nurses, as the single largest health profession in Australia (Health Workforce Australia, 2014), have the capacity to do more and can play a pivotal role in transforming Australia's health care system. As an existing workforce, the utilisation of nurses to address challenges currently facing Australia's health care system, presents a cost-effective solution. ACN's white paper *Value-based health care through nursing leadership* focuses on the need to shift the whole health system towards models that target core issues in our health and aged care settings, namely, the need to evolve funding models and empower nurses to focus on ***'value'***, facilitating nurses to work to their full scope of practice and providing the evidence-based services health consumers need most (Australian College of Nursing, 2020a). This is worth noting, as nurses in general practice are traditionally regarded as working ***'for or on behalf'*** of a general practitioner (GP). This is often demoralising for nurses uniquely skilled as health professionals. For instance, the introduction of the *COVID-19 Temporary Medicare Benefits Schedule (MBS) Telehealth Service* (Department of Health, 2020a) was available to GPs, medical practitioners, participating midwives and allied health providers, but not initially to general practice nurses (GPN). Indeed, these changes led to job losses during COVID-19 (Halcomb, McInnes et al., 2020). While nurse practitioners (NPs) have access to the MBS temporary telehealth items, some GPNs have not been afforded the same opportunities, which limits the potential for this subset of C&PHC nurses to be used most effectively. Nurses in the C&PHC sector seeking access to MBS items must progress through existing career pathways and achieve nurse practitioner status (Halcomb & Ashley, 2019; Halcomb,

Ashley et al., 2018) before being eligible to apply for a Medicare Provider Number and access to MBS items. Until nurses are provided their own funding stream and remunerated for their valuable skill set, ACN anticipates mounting problems in the C&PHC sector. The impact of COVID-19 is a timely opportunity to critically review and reset our health system to meet the changing needs of the community now and into the future.

ACN understands the breadth of the C&PHC nursing workforce and the critical role it plays, particularly during times of crisis and more broadly in the preventive health space. The aim of this white paper is to open dialogue and provide the Australian Government with recommendations for system-wide reform in the C&PHC sector; to safeguard the health of all Australians; and to ensure equitable access to health services regardless of background, geographical location or financial status. ACN is keen to provide solutions and models of care capable of adding ***'value'*** to the individual, the community, the health care provider and Australia's health care system more broadly.

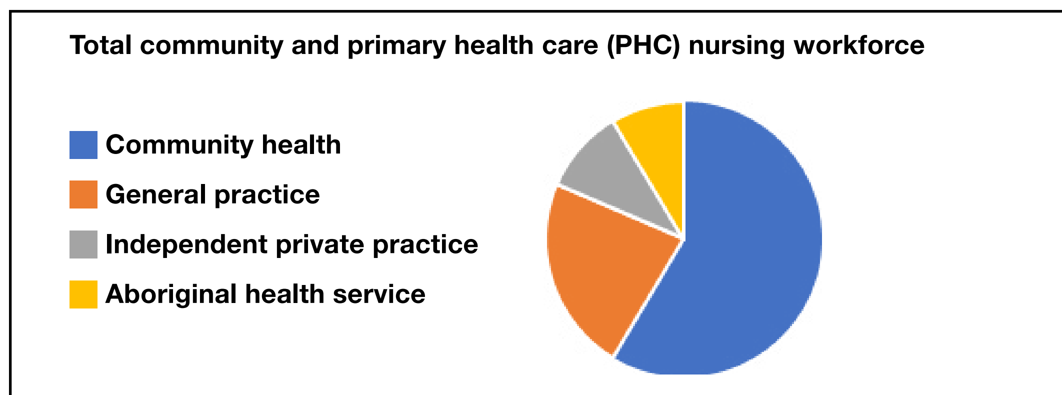
DIFFERENT ROLES OF NURSES IN DELIVERING PRIMARY HEALTH CARE

ACN recognises that primary health care nursing encompasses a broad and diverse set of roles and responsibilities within a wide variety of clinical settings in the community. C&PHC nurses provide *“socially appropriate, accessible, evidence-based, first level care”* (Australian Primary Health Care Nurses Association, 2020a) and represent frontline health care in their communities for myriad elements of health care, including the management of complex and chronic health conditions, disability, child health, health promotion and prevention activities, immunisation, domiciliary nursing and women’s health, among many others (refer to Box 1) (James et al., 2019; Guzys et al. , 2020).

Australian community and primary health care nurses

In Australia, nurses working in C&PHC settings make up 13.6% of the total nursing workforce (Department of Health, 2019a). Of these, 55% of nurses are working in community health care services, 28% in general practice, 13% in independent private practice and 4% in Aboriginal health services (Department of Health, 2019a). While it is difficult to ascertain definitive numbers due to the overwhelming number and variety of employers, Infographic 1 presents key features of the C&PHC workforce.

Infographic 1: Total C&PHC nursing workforce



The ‘community health nurse’ (CHN) makes up the largest proportion of C&PHC nurses, responsible for providing trusted and expert advice, education, treatment and management of a range of health needs in their communities, particularly for people in marginalised or under-represented groups.

CHNs work in a variety of settings, including schools, community and sporting events, Aboriginal and Torres Strait Islander health, and with migrant and refugee groups. Community health nurses act as an interpretive ‘bridge’ between acute health care and community services, embracing a social model of health to advocate for their communities (Australian Primary Health Care Nurses Association, 2020b). CHNs are often a critical part of a wider interdisciplinary team including GPs, allied health professionals and specialists in mental health, women’s health and Aboriginal health,

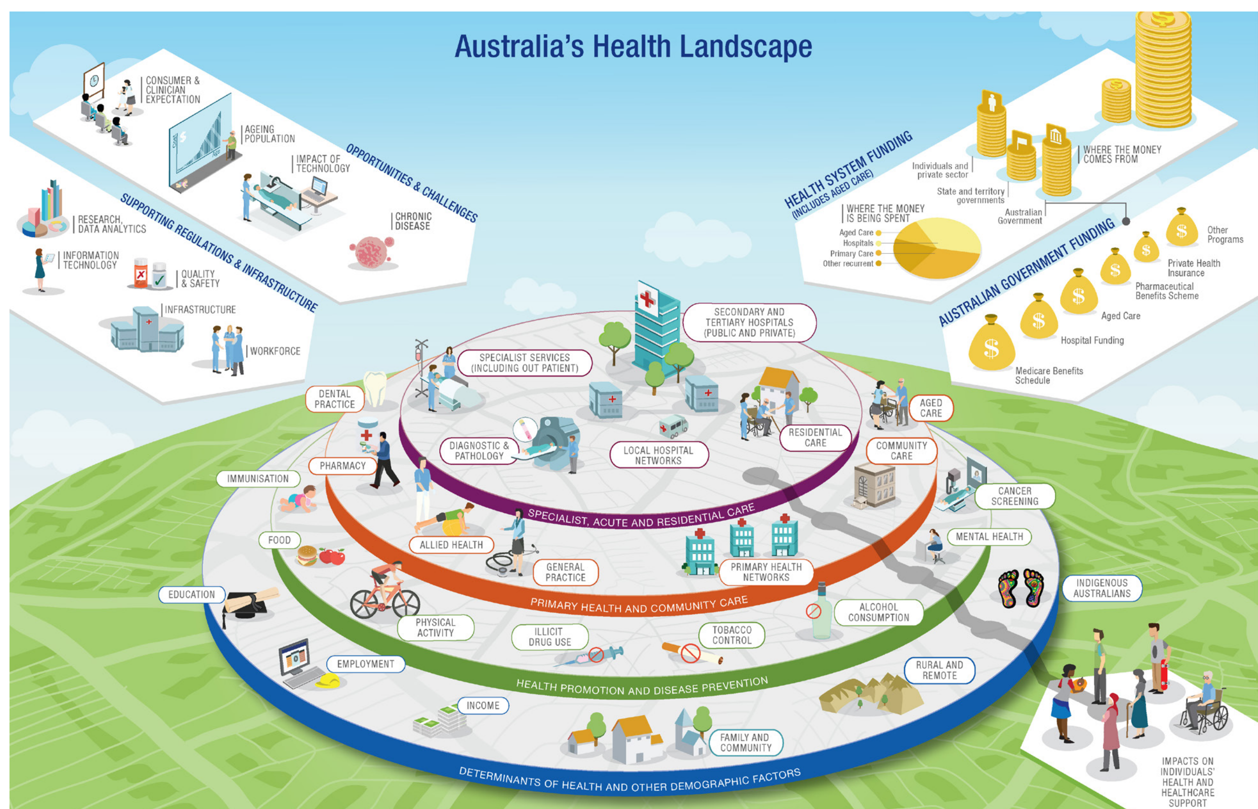
among many others. For example, one subset are nurses working in general practice who play a significant role in this setting (Australian Medical Association, 2015). As trusted and knowledgeable health care professionals in their communities, they are key drivers of prevention and health promotion, skilled clinicians and experienced educators, who foster connections between patients and various levels of health and community care (Halcomb & Ashley 2017). They are often responsible for enabling people with complex health needs to remain and receive care in their homes, reducing transfer to hospital (Department of Health, 2020b).

Funding structure for community and primary health care nursing in Australia

Australia's complex health system is reflected within its funding structure (Australian Institute of Health and Welfare, 2018b) shown in Infographic 2. Funding of the C&PHC sectors comes from all levels of government, as well as from non-government organisations, private health insurers, and individuals who have not received reimbursement for products and services (see Table 2) (Australian Institute of Health and Welfare, 2018b).

Well over half of all C&PHC nursing in Australia is delivered through state health activity-based funding arrangements through direct employment by hospital health services (HHS) or through brokerage agreements with non-government organisations (NGO) and Commonwealth-funded agreements with NGOs. This complexity of funding has led to location dependent inequities and inefficiencies in the health care experience of community members. It is vital any nursing workforce solutions include proposals to also support full mobilisation of all nurses already delivering care through state health and Commonwealth-supported funding, through advocacy to governments at all levels to commit to equitable resourcing of C&PHC nursing. This funding should ultimately be locally based and targeted to address the needs of individual communities.

Infographic 2: The Australian Health landscape



Source: Australian Government (2019c) https://www.health.gov.au/resources/publications/australias-health-landscape-infographic

Funding for Australian C&PHC nurses comes from a variety of funding structures.
Table 1 below illustrates the very complex funding structure.

Table 1. C&PHC nursing reflected within Australia's health care funding structure

Level 1. Acute and specialist care	Level 2. Community and primary health care	Level 3. Health promotion and disease prevention	Level 4. Determinants of health and other demographics
Acute and specialist care has a focus on hospital care where nurses are most visible. Community nursing care delivery occurs in Hospital Avoidance Programs such as: • Hospital in the Home/ acute/ post-acute/ health care delivery • Nurse navigator/ coordinator • Cardiac rehabilitation and / or heart failure • Respiratory health • Diabetes services • Renal and dialysis services • Spinal injury management • Community palliative care • Community mental health • Aged care rehabilitation care / Transition Support Program ***Registered nurses – State HHS employed or funded through brokerage for Hospital Avoidance Programs.**	Nurses deliver in general practice, in aged care settings and community health care service centres, through state HHS funding and Commonwealth funding of care through DVA, NDIS and specific aged care funding. The focus is usually on management of existing and ongoing chronic disease health needs. **General practice** covers many areas of nursing practice including women's health, men's health, aged care, infection control, chronic disease management, immunisation, cancer management, mental health, maternal and child health, health promotion, population health, wound management, illness prevention. ***General practice nurse (GPN) – MBS items and WIP** **Primary health networks** - PHNs work to reorient and reform the primary health care system by taking a person-centred and collaborative approach to medical services in their regions (Department of Health, 2020c). ***GPNs not employed by PHNs are involved with management of WIP.** **Aged care services** *Commonwealth Home Support Program (CHSP)* is an entry-level home support program that helps older people to live independently in their homes and communities (Department of Health, 2020d). It also provides respite services to give carers a break. ***Nurses not required at this level** *Home Care Packages Program* - supports older people with complex care needs to live independently in their own homes. It uses a consumer-directed care approach to make sure the support suits a person's needs and goals. Offers a coordinated mix of services that can include: • Help with household tasks • Equipment (such as walking frames) • Minor home modifications • Personal care • Clinical care such as nursing, allied health and physiotherapy services *Aged Care Assessment Teams* (Interprofessional team) *Transition Support Program* (Interprofessional team to case manage and deliver care). ***Registered nurses – Commonwealth funding of services to approved NGO aged care providers.** **DVA** ***Registered nurses – Commonwealth funding of services to approved NGO DVA care providers (Department of Veterans' Affairs, 2020a).** **NDIS** ***Registered nurses – Commonwealth funding of services to approved NGO NDIS care providers (National Disability Insurance Scheme, 2020).** **Community care** - publicly funded primary care organisations that deliver an integrated model of health care to their local communities. States and territories have primary responsibility for many areas of service delivery. ***Registered nurses – State, HHS employed and brokered NGO service employed members of interprofessional health care team.**	Nurses work in alcohol and drug services, public health, community mental health services, screening services such as breast and other cancer screening, health promotion, child health, school health, refugee health and immunisation (Commonwealth of Australia, 2020). **Cancer screening (e.g. breast screen)** ***Registered nurses – local and state funded/ employed and brokered NGO service employed members of interprofessional health care team.** **Mental health** ***Registered nurses – state funded/ employed and brokered NGO service employed members of interprofessional health care team.** **Alcohol, drugs and tobacco** ***Registered nurses – state employed and brokered NGO service employed members of interprofessional health care team.** **Cardiac health** ***Registered nurses – Commonwealth funded NGO service employed members of interprofessional health care team.** **Respiratory health** ***Registered nurses – Commonwealth funded NGO service employed members of interprofessional health care team. Diabetes services** ***Registered nurses – Commonwealth funded NGO service employed members of interprofessional health care team.** **Immunisation** ***Registered nurses – local and state government funded / employed, MBS funded GPNs and pharmacy settings.** **Refugee health** ***Registered nurses – state funded/ employed and brokered NGO service, including MBS funded GPN employed members of interprofessional health care team.** **Child health** ***Registered nurses – local and state government funded/ employed** **School health** ***Registered nurses – state government funded/ employed Public health nurses** ***Registered nurses – state government funded/ employed**	Determinants include the things that affect health outcomes and determine our vulnerability. Can be where we live, age, social connections, cultural factors, income and education. This is the care delivered at home (includes RACFs and prisons), in our places of work and in our rural and remote communities. **Community controlled Aboriginal & Torres Strait Islander primary health care services** ***Registered nurses** – not directly employed by PHNs are involved with management of WIP and support MBS claims where applicable. More strongly geared towards Aboriginal health practitioners and GP-led care, quite often nurses are in a more support role for the AHPs. **Rural and remote communities** ***Registered nurses** – are not directly employed by PHNs and in this context GPNs are called RANs (remote area nurses). As above, may be recruited through the RWA recruitment support team with relocation grants and scholarships and CPD offerings. Some salaried nurse practitioners exist but not many, usually RANs who can also claim for some MBS items on behalf of GPs. Also undertake chronic conditions care planning, adult health screening and child health screening that is all signed off and claimed by the GP. **Correctional services** ***Registered nurses – state employed and brokered NGO service employed members of interprofessional health care team.** **Homelessness services** ***Registered nurses – state employed and brokered NGO service employed members of interprofessional health care team.**

BARRIERS AND ENABLERS TO NURSES WORKING TO THEIR SCOPE OF PRACTICE

ACN is committed to ensuring Australia's primary health care nurses are empowered and supported to work to their full scope of practice. Evidence suggests when nurses can effectively utilise their skills, knowledge and expertise in the provision of health care, patient outcomes improve dramatically, while job satisfaction and retention increase (Australian Primary Health Care Nurses Association, 2017; Merrick et al., 2012; Murray-Parahi et al., 2017).

In Australia, nurses must be registered with the Australian Health Practitioner Regulation Agency (AHPRA) and meet the Nursing and Midwifery Board of Australia's (NMBA) professional standards in order to practise. These professional standards include a code of conduct, standards for practice and code of ethics which define the expectations for nurses and therefore inform the scope of practice for nurses (Australian Health Practitioner Regulation Agency, 2020). Additional professional practice standards specifically for nurses working in general practice have been developed to define and communicate the specific skills that nurses offer in this setting (Halcomb, Stephens et al., 2017; Australian Nursing and Midwifery Federation, 2014).

Barriers

There exists a range of barriers to C&PHC nurses working to their full scope of practice. These include: lack of clarity around role definition; inadequate and inflexible funding streams, particularly for GPNs in rural and remote areas; poor employment conditions and remuneration compared with acute care nursing; small nursing teams or solo practices that do not facilitate professional support; few incentives or structural supports for career advancement; limited professional development or training opportunities, particularly in remote settings; and lack of primary care-specific emphasis in education for many C&PHC nurses (Halcomb, Davidson et al., 2008a; McInnes et al., 2017a; McKenna et al., 2015).

For RNs surveyed in a 2019 Australian study, the biggest obstacles were a distinct lack of remunerative benefits or supportive guidelines, as well as unsupportive employers and other health professionals. Meanwhile, professional satisfaction and patient needs were strong motivations for individual nurse expansion of scope of practice (Birks et al., 2019). In a 2016 report, the American Nurses Association Professional Issues Panel Steering Committee identified various barriers that prevent RNs from working to the full scope of their education and training, and made recommendations to address these (Thomas et al., 2016). While this report was based on RN practice in the US, the recommendations provide relevant insights for the Australian context. Barriers included variations in state regulations, outdated training and transition to practice programs, insufficient research investment and lack of employer accountability for collaborative academic practice programs. The Panel also identified barriers to nurses providing culturally competent care, also of concern in the Australian context. These included insufficient recruitment efforts and cultural, religious and racial preferences not being adequately respected or understood. Australian research has identified lack of reflection of interprofessional practice in academic and practice models, few nurse-designed collaborative models and limited access to workforce data as key barriers to effective interprofessional environments (McInnes et al., 2017a; McInnes et al., 2017b).

NPs also face barriers in working to their full scope of practice. In a recent study, Smith et al. (2019) used semi-structured, in-depth interviews with primary NPs and colleagues to explore the macro- and micro-level barriers and enablers to NP scope of practice. The study findings suggested that at the macro level, legal, regulatory and economic factors determined the ability of NPs to utilise their full scope of practice. At the micro level, most influential were local health service and community attitudes, particularly regarding role clarity, professional hierarchies and embedded role expectations (Smith et al., 2019). Managers and decision-makers need a better understanding of the NP's clinical importance in order to successfully make the most of the NP in an integrated system.

Further, Beadnell (2019) outlined the challenges NPs face, even after undergoing all necessary authorisation and advanced practice training. The article, which highlights one example of a common experience, drew upon an interview with Jo Perks, one of the first NPs authorised in Australia in 2005. Despite her authorisation, it took Perks several years to get a stable position with fair remuneration in her area of women's health. While Perks' access to prescribing and MBS items has improved over time, she still faces various obstacles in providing adequate and quality care to her patients, including an inability to order diagnostic tests or initiate medications. Perks works with many women from marginalised or CALD backgrounds who are reluctant to see a male GP. The current system forces Perks to find a supportive GP to ensure quality continuity of care (Beadnell, 2019).

Lack of recognition and role clarity

For many C&PHC nurses, particularly GPNs, a fundamental barrier to working to their full scope of practice is a distinct lack of clarity around, and recognition of, their role (Halcomb & Ashley, 2017; Halcomb, Stephens et al., 2017). Confusion is often shared by the GPs they work with (McInnes et al., 2017c), which can lead to misinformation and poor practice.

While GPNs are expert health professionals, they are often perceived as ***'working for or on behalf of'*** the GP in their practice. This not only creates unnecessary tension and poor job satisfaction but can have implications for effective patient care. If nurses are unsure what their role entails and are not recognised for the work they do, they will continue to be unable to work to their full scope of practice (Halcomb, Stephens et al., 2017). This may exacerbate nurse turnover and hinder efforts to attract and retain nurses (Halcomb & Bird, 2020a).

Inadequate and inflexible funding streams

Many C&PHC nurses, do not have access to adequate funding that would allow them to work to their full scope of practice (Halcomb, Davidson et al., 2008b). Australia's health care system reflects what the Government prioritises and pays for, and it currently does not pay for all nurses working in the C&PHC system. Without adequate funding, nursing will not be recognised adequately in the C&PHC sector and any potential for enhanced care will be missed.

Except for NPs, nurses do not have access to Medicare funding or MBS item numbers. In metropolitan areas, where GPs and NPs are more readily available, this inefficiency in the system may not be immediately obvious. However, for GPNs in rural and remote areas, where they are often the first or only point of contact for many in their community, the time it takes for a GP or NP to sanction even the most basic health care can cause major delays, hampering both the GPN's practice and patient care. In fact, the triple impact report released by the All-Party Parliamentary Group on Global Health (APPG) in October 2016, highlighted that:

> *"Nurses are often the first and sometimes the only health professional that people see and the quality of their initial assessment, care and treatment is vital. They are also part of their local community – sharing its culture, strengths and vulnerabilities – and can shape and deliver effective interventions to meet the needs of patients, families and communities."*
> (All-Party Parliamentary Group on Global Health, 2016)

An example that demonstrates this issue is wound care, which previously had an assigned MBS item number. This is no longer the case, which means in order for the practice to receive any financial benefit for wound care, a GP must examine and prescribe a treatment for the wound, regardless of the GP's education and experience in wound care relative to the nurse. This causes delays for the patient and takes precious time away from nurses' care for other patients. ACN does not believe that reinstating an MBS item number for wound care would address either this problem or broader inefficiencies. Rather, more open and flexible funding schemes that fund nurses to provide the kinds of care they are educated for and to act in the best interest of the patient would improve efficiency and optimise care for patients.

Research suggests current funding arrangements have a demonstrable, negative impact on patient outcomes, job satisfaction, practice efficiency and collaboration between doctors and nurses (McInnes et al., 2017c). For example, GPNs would like to do much more than they are currently able to, particularly in health promotion, education, patient assessment and management of chronic conditions (Halcomb & Ashley, 2019). Fee for service-funding models can hamper collaboration between GPs and GPNs (McInnes et al., 2017c). Current funding streams do not provide optimal prevention or management of chronic disease. With Australia's rapidly ageing population and the rise in complex and chronic disease, existing funding streams and their associated limits on scope of practice for C&PHC nurses must be reviewed to better reflect the changing needs of the Australian health care system.

Poor employment conditions

It is well established that C&PHC nurses, and GPNs in particular, often experience significantly poorer employment conditions and remuneration than their acute nursing counterparts, which further maligns this career pathway (Halcomb, Ashley et al., 2018; PayScale Australia, 2020). C&PHC nursing is often seen as a less attractive and less valuable area of nursing, despite primary health care accounting for the majority of health care that individuals receive across their lifetimes (Calma et al., 2019). C&PHC nurses play a critical role in keeping communities safe and healthy and should be rewarded accordingly.

C&PHC nurses also report stressful, inefficient and unrewarding work environments, with insufficient time to spend with patients (Halcomb & Ashley, 2017). It has been reported that some GPNs, particularly those working in small or isolated practices, are frequently tasked with undertaking the bulk of administration, which is rarely acknowledged or remunerated, and highlights poor resource allocation in many practices (Halcomb & Ashley, 2017).

Until C&PHC nurses are fairly compensated for their work, Australia's health care system will continue to see lower job satisfaction and retention rates in this setting, poor patient outcomes and significant workforce sustainability challenges, leaving the health care system unable to meet the needs of Australians into the future. This is important to consider as a significant shortage of nurses in Australia is expected (Health Workforce Australia, 2014). Projected shortfalls in the nursing workforce are approximately 85,000 nurses by 2025, and 123,000 nurses by 2030 under current settings (Health Workforce Australia, 2014).

Lack of incentive and pathways for career advancement

For many nurses, the least satisfying aspect of their role is a distinct lack of incentives to develop their practice or progress their careers (Health Workforce Australia, 2014). The career and education framework does not provide a useful approach to career building. ACN members working in C&PHC argue that they are rarely encouraged – and in fact are often discouraged – from undertaking further training and skill development. They are frequently told there is 'no point', it is a 'waste of time', and recognise they are not rewarded in remunerative benefits or career advancement when they do.

Career structures simply do not exist in the myriad small businesses and NGOs in which C&PHC nurses work. There is a need to focus on creating leadership positions within primary health networks (PHNs) for nurse leaders to grow and support the nursing workforce in the community.

The small business model of general practice, the restructuring of the health care system towards PHNs, and the highly dispersed nature of primary health care more broadly, mean that many C&PHC nurses have lost some existing networks, further impacting their attempts to create cohesive career frameworks.

Inadequate training opportunities

One of the major barriers to scope of practice in primary health care nursing is insufficient education incentives to adequately prepare for C&PHC both in initial RN and EN education, and in further study or professional development. There are several factors limiting the ability of education to adequately prepare aspiring C&PHC nurses:

- There is very little funding available for nurses working in primary health care.
- Placements in community and general practice settings are more complex and less cost-effective, as smaller settings require smaller groups.
- There is no clear monetary benefit or allowance for offering such education in C&PHC settings, unlike education for acute care nurses who can be promoted to Clinical Nurse Specialist or Clinical Nurse Consultant.
- While specialist short courses are highly beneficial, postgraduate study is also required to provide overarching skill development in leadership, research, management and holistic care coordination.

On the positive side, professional organisations like ACN and Australian Primary Health Care Nurses Association (APNA) have been working determinedly to address educational opportunities, workforce development and funding opportunities in the C&PHC sector.

Enablers

Several enablers can enhance the ability for C&PHC nurses to utilise their full scope of practice, thus improving patient outcomes, job satisfaction and long-term workforce sustainability. These include greater autonomy and space; proactive and supportive management; mentoring and coaching; and improved education focused on C&PHC, preventive care, wellness and behaviour change. Having an identified practice nurse leader/manager, feeling that one's training and qualifications are utilised effectively, and feeling part of a network with opportunities for mentoring are all factors significantly correlated with higher job satisfaction (Halcomb, Bird et al., 2020b).

Autonomy and space

For many C&PHC nurses, one of the most satisfying and rewarding aspects of their role is a sense of autonomy in managing their work and scope of practice (Halcomb & Ashley, 2017). This can be highly dependent on the setting in which they work and the attitudes of their employers. If C&PHC nurses feel they have agency in planning and executing their clinical practice, without undue interference or limitations, they will be more empowered in utilising their full scope of practice.

Proactive management and mentoring

One of the biggest enablers for C&PHC nurses is having managers and mentors who nurture them to seek out opportunities for development and promotion. The importance of role-modelling and mentorship is well-established in the nursing literature, particularly in under-appreciated and under-recognised areas (Fedele, 2019; Gibson & Heartfield, 2009; Mills et al., 2005; Moran et al., 2002; Vinales, 2015). The ability to see peers at a more advanced stage of their career allows those new to clinical practice to identify potential career advancement pathways and assures them they can have a long-term future in primary health.

Education, training and placement

As outlined in the Barriers section, many C&PHC nurses at times lament the acute, hospital-centric focus of nursing education which on occasions fails to adequately prepare them for the increasingly complex needs of consumers in C&PHC settings. Opportunities to access postgraduate study, C&PHC-specific courses and placement which focus on preventive care, risk communication and behaviour change (James et al., 2019), health promotion, wellness, chronic disease management and wound management would enable C&PHC nurses to feel more clinically prepared, confident and better equipped to provide primary health care within their communities.

While this is happening to a degree, more accessible funding, for example in the form of scholarships, would be beneficial. For nurses in rural or remote areas, or from low socio- economic areas, scholarships could be offered to ensure equitable access to professional development. Any C&PHC-specific courses should follow nationally consistent standards.

ACN believes C&PHC nurses should be empowered and supported to work to their full scope of practice. At both micro and macro levels, C&PHC nurses must be meaningfully recognised and fostered as fundamental members of integrated, multidisciplinary health care networks, who bring unique skills, knowledge and expertise to the delivery of quality care. This means clarity around and respect for their role; relevant and targeted professional development and mentoring to enable for successful transition to practice in C&PHC settings; fair remuneration and other incentives to develop their practice; and greater autonomy to conduct their work as health care professionals.

MODELS OF CARE

ACN strongly advocates for innovative, multidisciplinary and integrated C&PHC models of care that reflect rapidly shifting political, social, economic and regulatory trends, and better serve the increasingly complex needs and priorities of health care consumers, communities and the broader health care system (Thompson et al., 2019). Nurses are a fundamental – and often underutilised – source of positive disruption and innovation for health care systems. They can provide agile, affordable care for individuals and the community, while maintaining and extending existing high standards of safety and quality.

As highlighted in the *Scope of practice* section, C&PHC nurses face a range of barriers in providing the best care possible in their communities, such as roles not reflecting the extent of practice scope, inadequate remuneration and a lack of career progression pathways. One of the most significant challenges, however, is inflexible and outdated models of care and funding structures that limit the C&PHC nurses' scope of practice, often relegating nurses to acting ***'for or on behalf of GPs'*** in their practice.

In this section, ACN proposes a suite of complementary, evidence-based models of care that enhance patient outcomes, improve nursing development, recognition and progression, and promote healthier communities and more efficient health care systems.

Nurse-led models of care

ACN believes nurse-led models of care provide trusted, respected and expert primary health care. In its advocacy role, ACN has provided compelling evidence and rationale for the widespread support of nurse-led models of care in all health care settings, particularly in primary health care. In a 2018 position statement, ACN argued that ***community and primary health care nursing*** is integral to ensuring optimal health outcomes for individuals across their lifespan, applying social models of care that meet the health needs of communities, while considering social, economic and environmental health determinants (Australian College of Nursing, 2018). In a 2017 white paper, ACN outlined the importance of ***nurse leadership*** in improving patient outcomes, promoting positive work environments, financial performance and retention (Australian College of Nursing, 2017). In a 2019 position statement, ACN highlighted the crucial ***role of nurses in chronic disease prevention and management in rural and remote areas***, recognising that many communities are reliant on nurse-led services to provide person-centred and holistic care, empower health ownership among communities and lead health promotion efforts (Australian College of Nursing, 2019a). In a 2020 white paper, ACN provided an implementation toolkit for ***establishing a nurse-led palliative care service***, recognising that nurses are the largest group of health care professionals who provide physical, emotional, social and spiritual care to people with life-limiting conditions, providing much-needed continuity of care (Australian College of Nursing, 2020b). In a 2020 position statement outlining the ***effectiveness of nurse-led interventions in the assessment and management of overweight and obese children and young people***, ACN argued nurses are well placed to deliver feasible, acceptable and effective interventions, with studies reporting reduced rates of overweight and obesity, improved diet and increased physical activity associated with such interventions (Australian College of Nursing, 2020c).

There is substantial evidence to suggest nurse-led models of care can not only improve patient outcomes and compliance with lifestyle change, treatment and medication, but can also reduce costs and unnecessary hospitalisations (Halcomb, McInnes et al., 2019; Halcomb, Moujalli et al., 2007). In the Australian Capital Territory (ACT), walk-in-centres were established in 2010 providing

free primary health care services to the community across five locations without the need for an appointment. These nurse-led clinics offer “advanced practice nursing care, innovative and cost-effective nurse-led models of care [which] aim to improve access to health care and give people choice while also enhancing the patient’s experience” (Fedele, 2020). These clinics are run by highly skilled nurse practitioners and advanced practice nurses who “undertake comprehensive assessment, provide timely person-centred care, opportunistic education and support, continuity of care and link patients to other health professionals and services” and take pressure off emergency departments (Fedele, 2020).

While more robust evidence is needed to establish when and in what contexts nurse-led interventions are most effective for different disease groups, studies have found demonstrable improvement in patient outcomes, long-term lifestyle change or overall health promotion efforts when compared to traditional doctor-led models of care. These studies have explored the role of nurse-led interventions in identification, recall and management of people living with diabetes, hypertension, mental illness, chronic disease and those attempting to quit smoking (Clark et al., 2011; Halcomb, McInnes et al., 2019; Keleher et al., 2009; Stephen et al., 2018; Zwar, Hermiz et al., 2017; Zwar, Richmond et al., 2015).

Integrated person-centred care systems (IPCS)

Nurses have a key role in developing and delivering integrated person-centred care. The concept is simple and involves nurses working in one team with other health professionals to provide care to the local community. Nursing work has always focused on connecting people and acting as advocates for people in care. The main challenge is that health services tend to work in silos, impacting the ability of nurses to work to their full potential and preventing the type of care people want to receive in the community, including continuity of care and access to the right care in the right place (National Health Service England, 2019).

An IPCS provides a different model for care provision by:

- Allowing nurses to work to their full scope of practice and provide the best care to patients without organisational barriers.
- Providing patients with a seamless journey from referral to the end of their care; less complicated care pathways; easier navigation of care; care that is closer to home.
- Reducing the number of times patients must answer the same questions from different providers.
- Having one team of clinicians working together, with the opportunity to gain a greater understanding of each other and communicate effectively.
- Challenging nurses to take the next step as leaders by giving them opportunities to more easily navigate the health system as advocates for their patients and the opportunity to train in different specialties.

Transforming the C&PHC sector to an IPCS will take time and require a systematic approach to building relationships, structure and governance frameworks, capacity and capability in the system, and the development of new roles (National Health Service England, 2019). Given that the National primary health care strategic framework (Department of Health, 2013) dates back to 2013, it is more pertinent than ever to redesign the primary health care system, shifting towards an IPCS. Providing the right care at the right time in the right place, closer to home through integrated care hubs acting as an interface between acute and primary health care offers a solution. Such nurse-led models could link specialists and work within PHNs to avoid emergency department admission while working collaboratively with the local PHN.

Nurse navigator

There is growing discussion around the increasingly important role nurse navigators could occupy in case management for health care consumers in C&PHC, particularly given the rapidly growing population with complex and chronic conditions (McMurray et al., 2018). Nurse navigators act:

> *"… as the pivot person in the interdisciplinary team, [making] a significant contribution to health reform by working towards patient-centred care, wherein patients receive timely, seamless, culturally appropriate guidance and support for developing health literacy".*
> (McMurray & Cooper, 2015)

Nurse navigators assist patients with complex conditions and overlapping co-morbidities to integrate services and address a fragmented and often impersonal health system, using expert clinical and social skills and robust communication (Byrne et al., 2020). Nurse navigators also optimise digital health records and streamline access across the primary and acute systems.

If nurse navigators – currently funded through HHS – were jointly appointed through HHS and PHNs, current gaps and inefficiencies could be addressed. Presently, any successful "straddling" of the systems is a result of effective relationship and network building of the individual nurse navigator, rather than any structural support for their role.

Telehealth and virtual health care

Even before the COVID-19 pandemic, telehealth provided critical primary health care to vulnerable and isolated groups, such as senior Australians, those in Aboriginal and Torres Strait Islander communities and those living in rural and remote areas with limited access to health care (see Definitions).

Considering the shifting health care landscape as a result of COVID-19, however, it is clear that telehealth needs ongoing support and funding, as a permanent element of the health care service mix. During the crisis, nurses have continued working with consumers, allowing them safe, flexible and convenient access to the health care they need (Australian College of Nursing, 2020d).

Digital technology has enabled people to stay connected during the pandemic, while the rapid expansion of virtual health care has meant long awaited efficiencies, workplace flexibility and improvements in access to care are being realised. With the opportunity to implement virtual health care models, the capacity to transform Australian health care system should be on all Government agendas. Virtual health care offers the chance to future proof our health system, supported by recent efforts to ensure digital gains are made a more permanent fixture.

While telehealth offers a more even playing field for primary health care access, it requires changes to ensure it continues to meet the needs of individuals, their communities and the health care system at large. Between March and June 2020, it was reported that NPs claimed 39,301 COVID-19 telehealth services, midwives claimed 6,293 and practice nurses and Aboriginal and Torres Strait Islander health practitioners claimed 81,079 (Services Australia, 2020).

Telehealth is not a substitute for face-to-face visits to health care providers, but it can provide a flexible and convenient option to supplement traditional visits. Telehealth may also improve coordination of care by allowing for case conferencing between a patient and the various members of their care team, such as their nurse, GP, allied health providers and specialists. Virtual health care must be underpinned by a strong clinical governance framework that ensures high levels of safety, quality and effectiveness.

Voluntary Patient Enrolment Scheme

In the 2019-20 Budget, the Australian Government announced a voluntary patient enrolment (VPE) initiative for older Australians aged 70+ years (or 50+ years for Aboriginal and Torres Strait Islander peoples) to support continuity of care and career pathways. The scheme would enable patients to voluntarily enrol with their regular general practice to encourage an ongoing, high quality and person-centred relationship (Department of Health, 2020e; Medical Director, 2020). This would still allow for the patient to see other members of their care team within the general practice and enrolment with a particular practice could be withdrawn at any time. The VPE scheme was intended to be launched in July 2020 but has been delayed due to COVID-19. ACN recommends telehealth be supported under this scheme.

NATIONAL STRATEGY FOR THE COMMUNITY AND PRIMARY HEALTH SECTOR

In order to meet the health care needs of patients and the community, it is critical the Australian Government considers how best to optimise the contribution of nurses and midwives, reflecting the objectives of the Australian Government's Primary Health Care 10-Year Plan. The ***Long term national health plan*** (Department of Health, 2019b) released in August 2019 includes the *10-year primary health care plan for Australia*. Stronger primary care is outlined in the first pillar of the 10-year plan in "guaranteeing Medicare and improving access to medicines through the Pharmaceutical Benefits Scheme (PBS)". The Australian Government pledged $550 million for a *stronger rural health strategy* to build a sustainable and high quality health workforce in rural and remote communities, bringing an additional 3,000 doctors and 3,000 nurses to these areas over 10 years. Under the strategy, education will be provided in rural and remote areas so that nurses and allied health professionals can have an expanded role in a multidisciplinary team.

It is also important to recognise how the COVID-19 pandemic has transformed the delivery of primary health care in Australia. Reforms outlined as part of the *10-year plan*, such as telehealth, were implemented in a matter of weeks between March and April 2020. This included 283 new temporary Medicare telehealth items, effectively demonstrating alternative ways to access health care services in the future. Unfortunately, these reforms failed to recognise the unique contribution of C&PHC nurses particularly around access to MBS telehealth items (Halcomb, McInnes et al., 2020). For this reason, ACN urges the Government to identify recommendations for priority actions under the enablers of primary health care reform, to improve access to safe, timely and appropriate nursing care.

Governance framework for the C&PHC sector

The ***National model clinical governance framework*** developed by the Australian Commission on Safety and Quality in Health Care in 2017 provides a sound starting point for implementing a C&PHC governance framework effectively to support safer and better care for communities (Australian Commission on Safety and Quality in Healthcare, 2017).

The following governance-specific elements have been noted as important in supporting integrated care across the C&PHC and hospital sectors:

- *"Joint planning… Governance arrangements [including] formal agreements such as memoranda of understanding (MOUs), joint board memberships and multilevel partnerships in the planning process.*
- *Integrated information communication technologies… particularly, a shared electronic health record, and systems that link clinical and financial measures.*
- *Effective change management… requiring a shared vision, leadership, time and committed resources to support implementation.*
- *… shared clinical priorities, including the use of multidisciplinary clinician networks, a team-based approach and pathways across the continuum to optimise care.*
- *Aligning incentives to support the clinical integration strategy… [including] pooling multiple funding streams and creating equitable incentive structures.*

- *Providing care across organisations for a geographical population… [requiring] a form of enrolment, maximised patient accessibility and minimised duplication.*
- *Use of data as a measurement tool across the continuum for quality improvement and redesign… [requiring] agreement to share relevant data.*
- *Professional development supporting joint working… [allowing] alignment of differing cultures and agreement on clinical guidelines.*
- *… consumer/ patient engagement… achieved by encouraging community participation at multiple governance levels.*
- *… adequate resources to support innovation to allow adaptation of evidence into care delivery."* (Nicholson et al., 2014)

THE FUTURE OF COMMUNITY AND PRIMARY HEALTH CARE NURSING

The Australian College of Nursing advocates for a primary health care system that values and substantively supports the critical expertise nurses bring to enhancing the health of individuals, communities and the wider health care system. To achieve this, several areas require addressing: nurses working to their full scope of practice; shifting how health care is funded; actively enhancing the sustainable supply and availability of nurses (Lane et al., 2017); building research capacity among nurses to build evidence and explore innovative models of care and their impact on health outcomes; encouraging the use of advanced practice models through funding and research; and offering more holistic payment frameworks, with a value-based health care approach with blended payment models inclusive of bundled payments.

Nurses working to their full scope of practice

The future of C&PHC nursing should be underpinned by a system that empowers nurses to work to their full scope of practice, recognising their skills, knowledge and holistic, person-centred approach.

ACN recognises one of the greatest barriers to current provision of primary health care is persistent limits on nurses' scope of practice. Consultations undertaken by the MBS Review Taskforce revealed similar sentiments with nurse practitioners and practice nurses reporting that their expertise was being underutilised. ***The interim report to the Minister for Health 2016*** (Department of Health, 2016) stated that *"by far the most prevalent concern was that allied health professionals and nurses (including nurse practitioners) should be able to perform a greater variety of MBS services, including providing referrals to specialists or requesting diagnostic tests."*

ACN recommends developing and allocating specific Medicare item numbers for nurses, for both in- person and telehealth appointments. ACN also recommends ending the stipulated number of eligible MBS consultations per annum for those with a provider number for Aboriginal or Torres Strait Islander peoples and those requiring chronic disease management. There are other opportunities for nurses with relevant graduate qualifications to perform MBS services including cervical screening and immunisation. In the ***Educating the nurse of the future report*** (Department of Health, 2019c) of the *Independent review into nursing education,* there are also recommendations to revise APN requirements to encourage broad primary care skill sets and NP education focused on primary care.

District nursing role in integrated community nursing teams

ACN recommends considering existing international models that demonstrate the benefits of integrated services for vulnerable communities, such as NHS Scotland's 'district nursing' model. In Scotland, the district nurse provides health and wellness services, enables self-care and delivers personalised and person-centred care in the community to support people staying in their home for longer. The district nurse is a senior practitioner and is supported by the wider community team, including health care support workers, RNs and NPs. Services are integrated appropriately with social care and other health services to ensure a full range of locally led, co-ordinated, high quality, accessible and well understood services are in place. The district nurse role is enabled to work without the constraints of hospital, boundaries, and to work flexibly with innovation being encouraged (National Health Service Scotland, 2017).

Similarly, at Buckinghamshire Healthcare NHS Trust, the Buckinghamshire Integrated Care System aligns teams at a strategic level, but also links them through co-location where possible to promote a shared team understanding of the patient and reduce duplication of work. This co-location brings health and social care services and staff together with specialties including psychiatry, community nursing, intensive support nursing, psychology, occupational therapy, speech and language therapy, physiotherapy and a dietitian. Moreover, co-location of teams is overcoming social isolation issues in the rural community locality (National Health Service England, 2019).

In this model, nurses lead care for older people aged over 75 years with a community nursing project that involves delivering appropriate care interventions before patients hit a crisis, to prevent unnecessary hospital admissions and support them to maintain their independence. The nurse acts as a trusted first point of contact that can link the patient with other health services. Nurses are supported by a local community resource to integrate with other service providers. Findings from this nursing project demonstrated increased referrals to memory clinic services, a 54% reduction in emergency department attendances, and average length of hospital stays of 9.2 days compared to the 10-day national average (National Health Service England, 2019).

Funding and remuneration

ACN believes to establish a truly sustainable, effective and value-based primary health care system, funding must shift away from a rigid, profession-centric, input-based model to a person-centric, innovative, outcome-based model. The Workforce Incentive Program (WIP) Practice Stream recently introduced by the Australian Government (Department of Health, 2020g), provides incentives to general practices who employ nurses, Aboriginal and Torres Strait Islander health workers and practitioners, and allied health professionals. The WIP Practice Stream includes:

- quarterly incentive payments to engage eligible health professionals
- a rural loading of up to 50%
- an annual loading for practices providing general practitioner services to Department of Veterans' Affairs (DVA) Gold Card holders.

The amount a practice gets depends on the:

- practice size
- type of eligible health professionals
- average hours eligible health professionals work each week
- type and location of practice.

ACN recommends increasing WIP funding to ensure an appropriate proportion is allocated to GPN employment, and to enable additional comprehensive care delivery for vulnerable populations and complex health conditions. ACN also recommends implementing a robust and accountable governance framework for the WIP to ensure GP clinics continue to employ GPNs.

As mentioned in the *Barriers* section, C&PHC nurses are often paid significantly less than their peers in acute care. This disparity in remuneration underscores the disease-centric focus of Australia's health care system, focusing on treating the symptoms of the sick, rather than wellbeing and prevention. ACN urges substantive changes to the way health care is funded and prioritised in Australia, placing far greater emphasis on empowering communities to keep themselves healthy and well.

Enhancing the supply and availability of nurses and advanced practice nurses

ACN strongly encourages governments and health care organisations to invest in the long-term sustainability of Australia's C&PHC and APN nursing workforce, in order to meet the needs of an ageing population with increasingly complex and chronic conditions. There also continues to be significant inequities in access to quality primary health care, particularly for people in rural or remote areas, those living with disability, mental illness or from Aboriginal and Torres Strait Islander or CALD backgrounds.

In C&PHC settings, APNs provide sophisticated leadership, guidance and expertise in provision of health care meaning that they are critical to navigate complexity and fragmentation (Australian Nursing and Midwifery Federation, 2014). Actively enhancing the sustainable supply and availability of APNs to support the health of Australians in areas of disadvantage, is best achieved through provision of education, clinical skill development, scholarships and training positions, particularly in rural and remote regions (Currie et al., 2019; McKenna et al., 2015; Williams et al., 2019). In **Educating the nurse of the future – report of the independent review of nursing education**, Emeritus Professor Steven Schwartz recommended advanced nursing practice requirements be revised to encourage the formation of the broad skills required in primary practice and that education of NPs be oriented towards primary care, particularly in regional areas (Department of Health, 2019c).

Well supported coaching and mentoring programs will provide clearer career pathways for all nurses. ACN, in collaboration with its Nursing in the Community (NiTC) Community of Interest could offer a mentorship scheme to partner experienced nurse leaders with aspiring nurses in C&PHC to mutually develop leadership skills.

Nurses at all levels must be able to work to their full scope of practice, which can only be achieved through ongoing education and development, and organisational resources.

Encouraging advanced practice models with research and funding modelling

ACN sees widespread adoption of advanced practice models as critical for the future of C&PHC nursing. However, there is insufficient robust evidence on which to base such models. There has been limited support for C&PHC nursing research as funding has predominantly gone to professional organisations rather than university-led groups, impacting the quality and scope of evidence produced. Substantial seed funding for both local pilot studies and large-scale, comprehensive studies is needed to develop evidence-based frameworks and toolkits for advanced practice models in PHC settings (Masso et al., 2019).

The *10-year long term national health plan* (Department of Health, 2019b) also provides an opportunity to consider how primary health care services can be funded to incentivise high quality care, improve access for those who need it and support better health outcomes across the population. Funding should be based on the demonstration of positive health outcomes: for people and communities, the promotion of teamwork and collaboration, and cost effectiveness and sustainability. ACN suggests developing financial modelling on the impact of providing access to the Medicare Benefits Scheme for registered nurses.

VISION

ACN's vision is for a multidisciplinary community and primary health care system that provides the right care at the right time by the right health professional.

Integrated and person-centred – engaging consumers as co-designers in the redesign of primary health care.

Clinically led – building nursing leadership in C&PHC sector and engaging our clinical leaders to build and drive improvements to change practice.

Evidence-based – influencing and adopting emerging innovation, generating and assessing the evidence and evaluating its transformative potential.

Value-driven – demonstrating value to patients and providers and delivering outcomes for the system with a value-based approach.

Sustainably funded – underpinning the best models of care.

Supported by innovative technology – embracing new technologies to better manage and support care.

RECOMMENDATIONS

1. Integrated, person-centred and outcome focused:

ACN recommends an integrated person-centred and value-based system that promotes seamless care pathways within a multidisciplinary team, greater health literacy, prevention, and empowerment of individuals to take ownership of their own health. Care systems should be integrated and responsive, person-centred and outcomes focused.

2. Workforce fit for purpose:

ACN supports an appropriately remunerated nurse health workforce operating at top of scope and supported by education, training and skills development. ACN recommends removing barriers to C&PHC nurses working to their full scope of practice through targeted funding for research, legislative changes to improve incentives and employment conditions, enhanced and relevant professional development and mentoring, further funding for transition to practice programs and clearer pathways for advancement.

3. Sustainable funding reform:

ACN recommends appropriate and sustainable funding reform that underpins the best models of care. The limited funding support offered by the MBS for NPs and RNs is currently restricting the Australian public's access to nursing care in the community. ACN advocates for increased access to the MBS for NPs and RNs. At the same time, ACN proposes that a collaborative exploration of new funding models supporting continuity of care across the acute and primary health care sectors be prioritised.

4. Leadership and culture:

ACN supports cultivating dynamic leadership and inter-professional collaboration and co-design, shared decision-making and effective change management to ensure cultural shifts in the system. ACN proposes developing cross-sector partnerships between health, aged care, disability and primary health/community services, sharing linked data and ensuring the services are funded to collaborate to improve health outcomes for all health care consumers. ACN supports trusted health stewardship with leadership that is connected, collaborative, proactive and transparent.

5. Innovation and technology which is future focused:

ACN supports innovation and new technologies to better manage and support care delivery.

6. Research and data and evaluation:

ACN proposes a systematic program of research led by academic nurse researchers, data sharing and evaluation to support continuous improvement and foster information systems that offer safe, secure and timely sharing of data across the health system, to facilitate timely responses to health care needs.

CONCLUSION

The emergence of COVID-19 has served to highlight inequities in the health care system. Inadequate or delayed access to services; fragmented services; administrative obstacles; a lack of shared data; lack of recognition of the social determinants of health; and inaccurate communication have all impacted health care service provision and patient outcomes during this time.

In a post-pandemic Australia, the expansion of virtual health care, a transition away from fee-for- service models to value-based care and an increased use of technology will be essential to rebuilding a more resilient, flexible and accessible health care system. The best place to start is by understanding what matters most to people and how the Australian primary health care system can respond innovatively.

As per the World Health Organization (WHO) statement, C&PHC is largely person-centred and addresses the majority of a person's health needs throughout their lifetime including physical, mental and social wellbeing. As a whole-of-society approach, C&PHC includes health promotion, disease prevention, treatment, rehabilitation and palliative care. This is inherently nurse-led and it is therefore critical that nursing is front and centre in any policy change in the C&PHC sector. The modernisation and redesign of Australia's primary health care system to a more integrated and multidisciplinary system, which is more efficient, equitable, affordable and focused on patients, is vital.

DEFINITIONS

Advanced practice nursing

Advanced practice nursing is *"the experience, education and knowledge to practice at the full capacity of the registered nurse practice scope. It is neither a title nor a role: it is a level of clinical practice that involves cognitive and practical integration of knowledge and skills from the clinical, health systems, education and research domains of nursing. The nurse practising at this level is a leader in nursing and health care. Advanced practice nursing is enabled through education at master's level"* (Australian College of Nursing, 2019b).

Bundled health care payments

Bundled payments are one of three main payment mechanisms that exist in health systems alongside fee-for-service and capitation. Bundled payment is a method in which payments to health care providers are related to the predetermined expected costs of a grouping, or "bundle", of related health care services. The intent of bundled payment systems is to decrease health care spending while improving or maintaining the quality of care. It is therefore important for the payment system to be flexible and adaptable. Hence, these payment methods are often blended to extract the additive benefits of each whilst minimising unfavourable outcomes (Australian Healthcare and Hospitals Association, 2015).

Bundled payments are also referred to as Practice Incentives Programs where general practices receive payments *"to continue providing quality care, enhance capacity, and improve access and health outcomes for patients*" (Australian Government, 2020a). This often allows nurses to be employed by the practice under these incentive programs.

Community and primary health care

Community and primary health care (C&PHC) is routinely the first point of contact people have with the health care system. A range of primary health care providers is accessible in this setting including but not limited to nurses, GPs, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers (Australian Institute of Health and Welfare, 2016; Department of Health, 2020f).

C&PHC addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations such as senior Australians, individuals living in rural and remote areas, Aboriginal and Torres Strait Islander peoples, LGBTQIA+ and those from CALD backgrounds (Australian Primary Health Care Nurses Association, 2020a). A community and primary health care approach includes three components:

- meeting people's health needs throughout their lifespan
- addressing the broader determinants of health through multisectoral policy and action
- empowering individuals, families and communities to take charge of their own health.

Coordinated Veterans' Care (CVC) Program

The CVC Program manages the care needs of DVA Gold Card holders living with chronic conditions and promotes health literacy, self-management and best practice care coordination.

The program *"aims to improve participant quality of life and decrease the risk of unplanned hospitalisation. Within a general practice setting, the participant, their general practitioner (GP) and a nurse coordinator work as a team to develop a care plan to:*

- *meet the health needs of the participant*
- *manage the participant's ongoing care"* (Department of Veterans' Affairs, 2020b).

Integrated person-centred care systems

Integrated person-centred care systems (IPCSs) involve *"the entire health care system, such that all services — community, primary, secondary, tertiary (and quaternary) — are integrated to achieve good health outcomes and to efficiently deliver a high quality of service to people over their lives.… Any given person in the current system may try to integrate services — developing care plans, communicating with fellow clinicians and involving allied health professionals, following up on hospital admissions and linking to family members to deliver quality outcomes"* (Productivity Commission, 2017). While IPCSs aim to improve health outcomes in addition to delivering a higher quality and more cost-effective services, this model may be difficult to achieve due to constraints of current funding models and poor links between information systems and various health providers (Productivity Commission, 2017).

Medicare provider numbers

A Medicare provider number or simply a 'provider number' is required by health care professionals seeking to *"bill, prescribe or request services that are eligible for a Medicare benefit"* (Australian Government, 2019a). A provider number is required for each practice location including when there is a change in address or health profession role, as provider numbers are not transferrable (Australian Government, 2019b).

Those eligible to apply for a provider number must be registered with the Australian Health Practitioner Regulation Agency (AHPRA) or an approved registration body and belong to one of the following health professional groups including medical practitioners, midwives and nurse practitioners, dental practitioners, optometrists and other allied health professionals (Australian Government, 2019a).

Unlike all allied health professionals and medical practitioners, only nurse practitioners and mental health nurses are eligible for a provider number (Australian Government, 2020b). Registered and enrolled nurses are not eligible.

Medicare Benefits Schedule (MBS) item numbers

The Medicare Benefits Schedule (MBS) lists a variety of consultations, procedures and tests, and the schedule fee the Australian government has set for each of these items. The role of the MBS is to provide Australian health consumers with financial assistance with the cost of medical services (Australian Medical Association, n.d.; Consumers Health Forum of Australia, 2010). It does not include medication which is covered under the Pharmaceutical Benefits Scheme (PBS). Individuals can claim a Medicare rebate benefit at 100% of the schedule fee for consultations provided by a general practitioner; at 85% for all other services provided by a medical practitioner in the community; and at 75% for private hospital services in consultation with the medical practitioner

(Australian Medical Association, n.d.). However, the service provider may charge more than the schedule fee, in which case the individual health consumer must pay the 'gap' or the 'out-of-pocket' costs (Consumers Health Forum of Australia, 2010). Access to MBS items is only available for health professionals who hold a provider number. Therefore, services provided by registered and enrolled nurses cannot be remunerated via this system unless in collaboration with a health professional who holds a provider number.

Nurse

In Australia, the term 'nurse' is an umbrella term which includes registered nurse (RN), enrolled nurse (EN) and advanced practice nurse (APN), including nurse practitioners (NPs). Nurses who work in general practice may be referred to as 'general practice nurses' (GPN) or simply 'practice nurses'. Nurses take a name often from their practice setting, e.g. community nurse, justice health nurse.

The International Council of Nurses defines a 'nurse' as:

> *"a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognised programme of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorised (1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research."*
> (International Council of Nurses, 2020)

Nurse practitioner

An NP *"is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role"* (Department of Health, 2019d). In addition to holding a general registration as a registered nurse, NPs also have demonstrated advanced nursing practice in a clinical leadership role (minimum of 5 years); have completed a required qualification; and have met the competency standards for NPs as per the Nursing and Midwifery Board of Australia (NMBA) requirements (Department of Health, 2019d).

Since 1 November 2010, eligible NPs in Australia have had access to the MBS and the PBS, which has supported a greater role for NPs in primary care services, aged care and in rural and remote settings (Department of Health, 2018). NPs can work either as an employee or in their own private practice; they are able to attract Medicare payments through the four time-tiered nurse practitioner MBS items which cover a broad range of services and through telehealth items. Eligibility to MBS item payments is contingent on having a Medicare provider number, working in a private practice, having professional indemnity insurance, and collaborative arrangements with a medical practitioner (Department of Health, 2018). NPs are excluded from providing MBS services if they are in a publicly funded role except for organisations with a section 19(2) exemption including NPs employed in rural and remote public health systems and at Aboriginal and Torres Strait Islander Community Controlled Health Centres (ACCHS) (Department of Health, 2018).

Public health

The World Health Organization defines public health as the *"science and art of preventing disease, prolonging life and promoting health through the organised efforts of society"* (Nutbeam, 1998). Public health activities focus on the entire spectrum of health and wellbeing and aim to provide all individuals the conditions and services to be improve their health, through legislation, policies and guidelines. Public health strategies aim to promote healthier eating and active living; reduce the harm caused by smoking, alcohol and drug use; and reduce the risk posed by potentially dangerous substances to ensure safe environments for all in the community.

Telehealth

The International Organization for Standardization (ISO) defines telehealth (International Organization for Standardization, 2014) as:

> *"'the use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance', while drawing a distinction between this and telemedicine, which is defined as the 'use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers'".*
> (Department of Health, 2015)

Telehealth was originally introduced by the Australian Government on 1 July 2011, with a focus on specialist consultation to patients in rural and remote locations (Gill, 2011).

Some of the clinical activities that can be supported by telehealth include:

- Pre-emptive health care management
- Managing chronic disease before acute attacks with targeted care for health cohorts (e.g. chronic disease, aged care, mental health)
- Promoting wellness amongst the community including preventative health
- Diagnosis, pre-treatment and post-treatment care
- Team based health care service provision (Royal Australian College of General Practitioners, 2020).

Value-based health care

Value-based health care (VBHC) is an innovative model of care that ensures the **right incentives** are in place to provide the **right care** at the **right time** for the **right price**, in the **right place** by the **right provider** (Global Access Partners, 2019). VBHC considers *"the health outcomes that matter to patients relative to the resources or costs required"* (Australian Centre for Value-Based Health Care, 2020).

The VBHC approach encourages improved equity and access to a health system and promotes outcomes that uniquely matter to patients. It focuses largely on preventive interventions, clinicians working to the highest standard of their scope of practice, improved patient appointment attendance (Victorian Agency for Health Information, 2019), along with a reduction in low-value care (i.e. an intervention which incurs a cost with little or no benefit, or risk to patient exceeds likely benefit) (Scott & Duckett, 2015).

Value in the VBHC approach can be understood using the simple equation below (Porter, 2016).

$$\textbf{Value} = \frac{\textbf{The set of outcomes that matter for the condition}}{\textbf{The total costs of delivering these outcomes over the full care cycle}}$$

Voluntary patient enrolment

Voluntary patient enrolment (VPE) is a continuous care model aimed at improving patient and population health outcomes through continuity of care in general practice that is flexible, proactive, and focuses on preventive and disease management (Department of Health, 2020e).

Workforce Incentive Program

The Workforce Incentive Program (WIP) has been in effect since February 2020, replacing the Practice Nurse Incentive Program (PNIP) and the General Practice Rural Incentives Program (GPRIP).

"The Workforce Incentive Program (WIP) provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas. The WIP also provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals"
(Department of Health, 2020g).

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