Exploring factors affecting uptake of extended scope of practice in rural areas

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Introduction

The geographical maldistribution of health workforce has remained a significant cause of concern internationally and in Australia (1-3). There is an argument, however, that while there is a shortage of specialised knowledge and skills in non-metropolitan areas, the problem is not so much the maldistribution of health professionals, as one of a maldistribution of skills. This raises questions about the potential for the development of innovative models of care using vertical and horizontal ‘skill transfer’ across interprofessional boundaries (4), creating new health care roles and expanded or extended scopes of practice for existing health professions (5-7).

The Nurse Practitioner (NP) model was initially introduced as one potential way to address health service gaps in rural and remote areas (8, 9), however the majority of NPs are employed in urban and inner regional settings (10, 11). There has been insufficient attention given to why the NP model has not fully realised its original aims in non-metropolitan settings and why there appears to have been resistance to this and other extended scope of practice models of care in Australia, unlike in other western countries, such as the United States, Canada and the Netherlands (12, 13).

Study aim

The principal aim of this study was to explore the lived experiences and the perceptions of NPs who work in non-metropolitan practice settings, as well as their colleagues (where possible), in relation to the barriers to and enablers of their extended scope of practice roles. Using the NP model as a case study, the further aim was to use a socio-institutional theoretical model of macro-, meso- and micro-perspectives to reflect on how such barriers and enablers may be generalisable to the implementation of extended scope of practice roles in the Australian health system, especially in rural and remote locations.

Method

Data collection was by way of semi-structured, in-depth telephone interviews, which were conducted by two members of the research team, both experienced in qualitative research methods and neither of whom have a health professional qualification.

Data analysis was undertaken by all members of the research team from an socio-institutional point of view (14, 15), using the macro-, meso- and micro-framework model, as articulated by Mulvale, Embrett (16) and Nelson, Turnbull (17). Two of the researchers independently coded the data to uncover the underlying content and meaning (18), with key themes and sub-themes abstracted. Coding of the data was managed using NVivo11 for Windows (QSR International). Following this process, the remaining authors read the transcripts to gain a preliminary impression of the data. Then all team members met, discussed and reached consensus on the themes and subthemes, grouping them according to the macro-, meso- and micro-framework. This culminated in the production of a theoretical model.
Findings

Participants included 15 primary informants (13 endorsed NPs and 2 NP candidates), along with 5 NP colleagues as secondary informants (1 endorsed NP not working in an NP role, 1 NP candidate, 1 social worker and 2 diabetes educators). All the primary informants worked in extended scope or advanced practice nursing roles, but not all worked as an NP. Of the 15 primary informants, one was an endorsed NP who worked in an extended practice role but was not employed as an NP.

Informants raised a number of issues which fell into the themes of enablers and barriers to extended scope of practice roles. These responses are summarised below.

**Micro barriers.** In their day to day practice, NPs encountered resistance from other HPs in the enactment of their role. This arose due to lack of understanding of the NP role and a lack of support from other colleagues, while in many instances, the presence of NPs clearly challenged traditional professional hierarchies and the status of existing health professions. For example, one NP explained that professional disagreements with doctors had resulted in them withdrawing their support, or “they remind you that you’re a nurse practitioner and not a medical specialist at that point, even when they’re wrong” (NP2).

Lack of role clarity was also seen to be an impediment to practice. Two of the NPs did not have a clear job description when they commenced and it was left to them to understand the gaps in service, and determine their scopes of practice. Finally, as much of the work of the NPs aims to address gaps in health services, it subjected them to risks associated with working in isolation; this was particularly evident in remote areas.

**Micro enablers.** The stories of resistance from other HPs described earlier, certainly do not indicate a blanket attitude to the NP role. Many participants indicated that they received good support from their colleagues, including nurses, AHPs and the medical community. Working with a team of other health professions, rather than as an isolated independent practitioner, was also viewed as an enabler to an NP’s practice. Finally, the capabilities and attributes of the NPs played an integral role in them gaining acceptance from other health professions, and in being able to contribute effectively to improvements in health service delivery. This represented an important micro-level enabler with attributes of diplomacy, negotiation, resilience, advocacy and promotion of the role viewed as particularly important.

**Meso barriers.** In Australia, the NP role continues to be reliant on state and national government funding, with evidence that local health services are reluctant to commit their own funding to support NPs, which are higher paid than nursing roles (19, 20). Other informants noted stressors associated with lack of staffing, inadequate breaks during shifts, fatigue and burnout and lack of administrative support. For example, two of our interviewees based in single clinician outposts fulfilled multiple clinical and administrative functions without the benefit of assistance. Further, most of the NPs in our study explained that there was a lack of broader recognition and understanding of the role in the community, representing a further meso-level barrier.

**Meso enablers.** Although the NP role was not widely known in the community, the NPs in our study found that patients and carers were generally receptive and supportive once they understood the services that the NP could offer. In addition to community support, most of our interviewees were reliant on formal and informal networks for support and advice. In many cases, NPs had built networks of GPs and medical specialists to call on for advice, or had established informal networks with other NPs. A final meso-level enabler was related to local policy and practice. In contrast to the
earlier examples which depicted organisational resistance to the NP role, there were instances where NPs found strong senior management support. Interviewees recounted cases where their local health service saw the value in NPs, and sought to implement the model, particularly for the management of chronic disease and in primary health care.

**Macro barriers.** There is a seeming conundrum in the employment market for NPs. Some of our informants moved towns and in some cases, states, to secure an NP role, while others recounted examples where endorsed NPs could not secure NP roles or could only find a part-time work. Further barriers included national policy and regulatory systems (Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) etc.) and professional indemnity and risk. In addition, sufficient funding for the continued viability of the NP role was noted as a significant barrier to practice by many of our informants. Access to education and mentoring was noted by many participants as a final macro-level barrier.

**Macro enablers.** Despite the above challenges to the enactment of the NP role, the role itself was viewed in a positive way by the incumbents. Further, most of our interviewees received scholarships while studying to become NPs (NP4, NP5, NP7, NP11, NP12, NP14). During their studies, other NPs had the benefit of being appointed to transitional roles (NP4, NP7).

**Discussion**

Despite the consistent evidence that NPs provide high quality care that is acceptable to patients (21, 22), the implementation of the NP role within the Australian healthcare context has, at best, been patchy. In the 17 years since the first NP was authorised to practise (10), only 1,418 NPs have been endorsed, representing a mere fraction of the total registered nursing workforce (23). This study has highlighted a range of persistent barriers to the enactment of the role that operate at the micro-, meso- and macro-levels. Key among these is the lack of awareness and understanding of the NP role by key decision makers and managers within the health services, which means that in many cases, funding for the role is short term or inadequate. Additionally, many of the NPs’ medical, nursing and allied health peers do not have a firm understanding of the NP scope of practice. Thus, NPs expend much of their time explaining, negotiating and advocating for their role, time that would be better served focussing on patient care. Moreover, there are several anomalies within regulations governing the MBS and PBS, which require NPs to seek medical approval for diagnostic investigations and pharmaceutical prescriptions that appear to fall logically within the NP’s scope of practice. On a positive, note, there was evidence that many NPs are being supported by their colleagues from the nursing, medical and allied health professions, particularly when those colleagues have had the opportunity to work alongside NPs, and gain a trust in, and understanding of their skills and expertise.

Three primary recommendations arise from our study. Firstly, the peak organisation for NPs, the Australian College of Nurse Practitioners (ACNP), not only needs to direct its advocacy efforts towards addressing the anomalies that exist within the MBS and PBS in relation to NP services, but secondly, to focus on promoting the role to senior managers within the health services; this latter target appears to a major block to the sustainability of the NP role. Thirdly, for health service managers, there is evidence that the acceptability of the NP role to nurses and other health professions is enhanced through NPs working in interprofessional teams, a strategy which has been found to promote understanding of the different health roles in rural contexts (24). Therefore, there is merit, if viable, in introducing the NP model in a context where they are supported by a team of other health professionals, rather than as a solo practitioner.
References

Presenter

Tony Smith is a radiographer with over 35 years’ experience. He has worked in public hospitals, private practices and the tertiary education sector. Since 2003, he has been employed at the University of Newcastle Department of Rural Health, initially in Tamworth and since 2012 in Taree, on the mid-north coast of NSW. Tony is currently the Deputy Director of the Department, which supports students from various health professions on long-term and short-term rural placements. Tony’s research interests focus largely on rural health workforce issues, especially around the development of new models of interprofessional and collaborative practice, particularly in medical imaging. He has a long-term interest in the education and support of GPs and nurses who perform limited-licence radiography in rural and remote locations, where no radiographer is available.