National Rural Health Alliance

Nurse Practitioner 10 Year Plan Consultation

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… healthy and
sustainable rural,
regional and remote
communities

National
Rural Health
Alliance

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Nurse Practitioner 10 Year Plan Consultation

The National Rural Health Alliance (the Alliance) welcomes the opportunity to make a submission to the Nurse Practitioner 10 Year Plan Consultation. The Alliance represents 42 member organisations encompassing healthcare professionals, health service and educational providers, and consumers located in or servicing rural, regional and remote (rural) Australia. The Alliance is committed to improving the health and wellbeing of Australians living in rural communities.

Introduction

Rural people and communities experience poorer health than their metropolitan counterparts. The maldistribution of the health workforce contributes significantly to this situation via reduced access to health services. Nurses make up the largest proportion of the rural health workforce. While there are still challenges to the adequacy of supply of the nursing workforce in rural areas, they are often the only health practitioner present when others are not. Nurse practitioners (NPs), endorsed by the Nursing and Midwifery Board of Australia, work at an advanced level and have the expertise and legal authority to practice autonomously across all health care contexts in Australia. Though the NP workforce is small, they currently contribute significantly to the health system in rural and remote Australia and have been found to increase access to care in many parts of the system relevant to rural health. Despite this, a series of barriers are currently preventing the expansion and further contribution of NPs to improving rural health outcomes. In this submission we explore these issues and present a series of recommendations for inclusion in the plan to address the barriers and facilitate acknowledged enablers to NP workforce development and utilisation over the next 10 years.

Rural Australian Health Context

At the population level, people residing in rural Australia have poorer health than their metropolitan counterparts. They experience a higher prevalence of numerous health risk factors, rate more poorly against the social determinants of health, and have reduced access to health services. Consequently, rural people experience a greater burden of disease, higher rates of morbidity and mortality, and have a lower life expectancy.

The persistent maldistribution of the health workforce in rural Australia, paradoxical to increasing need, is inextricably linked to reduced health status. While specialist general practitioners (GPs) with a broad scope of practice are required in larger numbers in rural areas, to service populations with higher healthcare needs, the GP workforce reduces from 119.0 full time equivalent (FTE) per 100,000 population in Major Cities[i], to 109.6 in regional areas and 73.3 in remote areas.[1] The pool of non-GP medical specialists and many allied health professionals is also greatly reduced outside of metropolitan areas (MMM1)[ii], regional centres (MMM2) and large rural towns (MMM3).[1] Nurses make up the largest proportion of the rural health workforce, though the population adjusted FTE working in medium (MMM4) and small rural towns (MMM5) is less than in all other areas.[1]

[i] Refers to the Australian Statistical Geography Standard – Remoteness Area (ASGS-RA), a geographical classification system developed by the Australian Bureau of Statistics based on service access. Categories include: Major Cities, Inner Regional, Outer Regional, Remote, and Very Remote areas.

[ii] Refers to the Modified Monash Model, a geographical classification system developed by the Australian Government Department of Health. There are seven classification groups: 1 (metropolitan), 2 (regional centres), 3 (large rural towns), 4 (medium rural towns), 5 (small rural towns), 6 (remote communities) and 7 (very remote communities).

Challenges to recruitment and retention of health practitioners and health professionals in rural Australia are multi-factorial, encompassing financial, professional and social domains. Running a viable health small business can be financially challenging in thin markets with limited through-put. Income streams are complex, and the business management burden is considerable. Practice can be professionally isolated, and challenges exist in accessing quality supervision and mentoring, along with professional development and opportunities for career progression. Socially, health practitioners and health professionals who are new to a rural area often have concerns about employment for their partner, schooling for their children and must leave their support networks behind.

The lack of a consistent and comprehensive health workforce in rural Australia, coupled with the vast distances in our large country, mean that many health services are not present within a reasonable distance of home. Rural people have difficulty accessing healthcare services due to travel requirements, waiting times, costs (due to gap payments, travel and accommodation and work forgone), and attitudinal barriers (concerns about privacy in small communities and a reduced tendency to seek help).

Nurse Practitioners in Rural Australia

Given the difficulty recruiting and retaining an adequate health workforce in rural areas, alternative models of service delivery have long been championed to improve access to care. Hence the development of the Rural and Isolated Practice Endorsed Registered Nurse (RIPERN or RIPRN) model in Victoria[2] and Queensland[3]. Many rural communities are dependent on nurse-led services.[4,5] As highlighted in the Consultation paper, the NP model in Australia was also initially developed to improve access to health care in rural and remote areas.[6] Given the supply of nurses in rural areas relative to other health practitioners, it makes sense that the nursing workforce be utilised in this way.

We note that the total NP workforce is small when compared to the overall nursing and midwifery workforce[7], with just 1419 NPs employed in Australia in 2020.[6] Despite this, after adjusting for differences in population size by MMM category, the largest number of NPs are employed in very remote communities (MMM7) – 16 per 100 000 population compared with 6 per 100 000 population for Australia overall[iii], making them well placed to contribute to health care delivery in this unique and challenging context.[6]

Data is not publicly available regarding the work setting and area of practice of NPs by geographical classification. Utilising the data presented within the Consultation paper regarding the overall NP workforce in 2020, it is evident that 41% worked in a hospital, 15% in a community health care service, and 14% in an outpatient service. Smaller numbers worked in settings related to primary health care, which is of relevance in rural Australia - for example, general practice, a residential health care facility, independent private practice or an Aboriginal health service. While 22% of the overall workforce reported working in the area of emergency, 14% reported working in an "other" area, of which 66% noted the delivery of primary health care. Access to comprehensive primary health care and acute care via an emergency department in a hospital is crucial in rural areas, where secondary and tertiary care may not be available. This data illustrates the current contribution of NPs to parts of the health care sector relevant to rural people and indicates potential to grow their contribution in rural areas, given the appropriate policy settings.

While alternative models of service delivery utilising health practitioners with advanced or extended scope of practice cannot replace professions who might be lacking, and ongoing work to improve

[iii] NRHA analysis of workforce data extracted from the Nurse Practitioner 10 Year Plan Consultation Paper, utilising population data by MMM obtained directly from the Department of Health for 2020.

our ability to recruit and retain the full breadth of health professionals in rural areas is crucial, many authors discuss the potential for NPs to help improve access to healthcare in rural areas.[4,8] There are currently regulatory and clinical governance structures in place to ensure the safety and quality of care provided by NPs and it is important to ensure that they reflect contemporary practice.

Given the current context of health service delivery in rural Australia, and as the burden on our healthcare system increases due to an ageing population and burgeoning chronic disease rates, ensuring skilled health care practitioners are empowered to work to their full scope of practice, with roles and tasks delineated accordingly, will assist in the management of workload and contribute to the provision of high-value care in the most efficient manner possible, ensuring care is available at the right place and the right time for city dwellers and rural people alike.

Successful Implementation of Nurse Practitioner Models of Care

As highlighted in the Consultation paper, there is a growing body of evidence about the positive impact of NPs across the health sector, on both health outcomes and human resource measures.[6] In a report commissioned by the Australian Government Department of Health and published in 2018, KPMG investigated the cost-benefit of NP models of care in aged and primary health care in Australia.[8] NP models were found to improve access to care for residents in aged care and support the quality and safety of care delivered by the broader aged care workforce, resulting in reduced hospital admissions. Models were found to be implemented successfully in the Aboriginal Community Controlled sector, improving access to culturally safe care. Similarly, NP models improved access to care in remote communities. KPMG determined that an expansion of 10 NP roles in primary care in rural and regional Australia could increase access to care for 10,000 people at a cost of $1.5 million per year.

Enablers of Nurse Practitioner Models

The following factors have been linked to successful implementation of NP models: establishing the model to meet a clearly identified need, interprofessional teamwork, and a generalist approach in primary care, aged care and rural settings.[8] In their 2019 qualitative study investigating the barriers and enablers to rural NP practice, Smith et al. found that NPs viewed their roles positively and that those receiving care and their carers were interested in NP care once they understood what could be provided.[9] Though experiences were variable, those NPs who received support from multi-disciplinary team members benefited from it, and working within a team was seen as an enabler to practice. The ability of NPs to communicate and build relationships was key in gaining acceptance with teams and improving service delivery.

Barriers to Nurse Practitioner Models

Given the opportunities for NPs to add value in the rural health sector, questions have been raised about why this component of the nursing workforce hasn't been utilised more widely and made more of an impact on rural health challenges to date.[9] While this is a complex issue, contributed to in part by the small size of the workforce, the lengthy and expensive education pipeline and lack of available scholarships, and the same issues with recruitment and retention faced by most health professions in rural Australia, a series of clear barriers have been identified across multiple levels of the health system.

Legal, regulatory and economic barriers

Funding has been identified by numerous authors as a significant impediment to increasing NP roles and their sustainability.[8,9,10,11] NPs are funded by various mechanisms, including within state

managed hospitals and health services, and in primary care via the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) or via general practice incentive payment schemes such as the Workforce Incentive Program (if they are not accessing the MBS). Despite gaining access to the MBS and PBS in 2010, access remains limited and hence private NP services may attract a co-payment[11] to make their practice financially viable, reducing access for all populations. Not only does the nature of a NP's access to the MBS and PBS affect the financial viability of their practice, but it has been found to limit their ability to work effectively to provide complete episodes of care.[8] This is particularly problematic for people in remote areas only intermittently served by a medical workforce but required to see a medical practitioner to get an MBS rebate for part of their episode of care (the majority or all of which is delivered by a NP).

Collaborative arrangements mandated as part of the legislative framework for MBS and PBS access by NPs require a relationship between privately practicing NPs and a medical practitioner or organisation that employs medical practitioners. While there are a variety of perspectives on the benefits and drawbacks of this requirement, is has been proposed that these arrangements impede growth of the privately practicing NP workforce in rural and remote areas due to a lack of consistent understanding and interpretation of the legislative requirement.[12]

The MBS Review provided an opportunity to reassess the contemporary nature of this funding scheme and its associated legislative requirements. In their report to the MBS Review Taskforce, the Nurse Practitioner Reference Group called for increased access to the MBS by NPs to bring it into line with contemporary practice and the actual cost of service provision, to improve access, reduce fragmentation, duplication, delays and inefficiencies.[10] Yet the MBS Review Taskforce did not endorse any of the recommendations of the Nurse Practitioner Reference Group, instead making their own recommendation to review alternative funding pathways.[13] Due to the observed impact of funding mechanisms on design of the practice model, innovation and sustainability, KPMG also called for an exploration of alternative funding models in their 2018 cost-benefit report.[8]

Limited employment opportunities for endorsed NPs have been reported in rural areas and linked to a lack of organisational support and a lack of funding flowing through organisations.[9]

Lack of data

When completing their cost-benefit analysis, KPMG found there was a lack of complete, reliable data regarding NP services at a granular level and this hampered their analysis. They recommended the development of data collection methods and tools as a high priority.[8]

Scope of practice clarity and delineation

Issues relating to scope of practice clarity have been linked to resistance from other health practitioners, often related to traditional views of professional status and heirarchy.[9] NPs should be recognised for their advanced education, clinical expertise and scope of practice and should never be seen as substitute medical practitioners. NPs are advanced practitioners capable of meeting unmet needs. The cost-effectiveness of NPs will only be realised if they are working to their full scope of advanced nursing practice[8], demonstrating and utilising the associated skills in leadership, education, systems management, and clinical care.

Awareness: value communication

Knowledge and awareness of the role of the NP, their model of care and the value they bring to the health system is variable among stakeholders and this hinders the broadening of their contribution to the health workforce.[8] Awareness raising via sharing data and evidence regarding NP models and their ability to meet needs would facilitate engagement with and coordination between stakeholders to increase the likelihood NP models are considered in local service planning.[8]

Rural workforce issues

NPs are not immune to the range of issues affecting recruitment and retention of the rural health workforce more broadly. Developing education pathways for rural and remote nurses to facilitate the growth of both the generalist and specialist skill sets required by NPs outside of major cities and creating a workforce pipeline to enable growth in the rural workforce has been suggested.[8]

Rural Area Community Controlled Health Organisations and Nurse Practitioners in Rural Australia

The Alliance proposes Rural Area Community Controlled Health Organisations (RACCHOs), broadly modelled on the Aboriginal Community Controlled Health Service, as a new model of service delivery in rural Australia designed to address the key barriers to attracting and retaining the rural health workforce. These organisations, which will be locally based, with strong local governance, management and leadership, will be non-government organisations designed to provide services in accordance with local needs. They will deliver comprehensive primary health care, utilising a multi-disciplinary team approach, offering a secure employment model to health practitioners and professionals based on block funding from the government.

We envisage NPs having a strong role within these organisations and that RACCHOs will address many of the aforementioned barriers and facilitate the enablers to practice, encouraging expansion of NP models of care in rural areas. RACCHOs will provide employment for NPs, enabling the provision of primary health care services without complete reliance on the MBS. They will enable work within a team to support multidisciplinary practice. Links with universities will facilitate education pathways and access to professional support and development. RACCHOs will be embedded within local communities and are likely to service residential aged care facilities and be linked with community pharmacies, and local health services, allowing NPs to work to their full scope of practice and deliver services across the community.

An example of this would be the embedding of clinical pharmacists and NPs within the aged care sector, to provide rational and responsive medication management and evidence-based deprescribing services, where polypharmacy is rife. Despite being a policy focus[14], this practice is hindered by the current funding models for both community pharmacy and NPs and the RACCHO model of block funded multi-disciplinary team-based care would address these barriers.

Recommendations

Given the evidence and discussion provided in this submission about the state of the rural health sector and the important contribution that NPs are making and could make in the future to rural health service delivery, access to care and therefore health outcomes, development of a comprehensive and well considered strategy for the future of the workforce is considered extremely important by the Alliance. Based on our assessment of this potential, coupled with the enablers and barriers to NP models of care, we provide the following recommendations for inclusion within the Nurse Practitioner 10 Year Plan:

1. That the legal and regulatory context of NP practice be reviewed to maximise the value of the care they provide by reducing unnecessary fragmentation, duplication, delays, inefficiencies and reducing disincentives to practice, while ensuring the provision of safe, high-quality care.

2. That funding models for NP models of care be reviewed, considering the findings of the MBS Review Taskforce and the Nurse Practitioner Reference Group, to improve access to their services, noting that RACCHOs present an alternative funding model for the profession in rural Australia.

3. Develop a strategy for the collection of data related to the NP workforce as a tool for evaluation, research, workforce interventions and to support funding requests, in order to provide evidence of their contribution to the system.

4. Build knowledge and awareness of the role of the NP, their model of care and the value they bring to the health system, by sharing data and evidence and engaging proactively with key stakeholders.

5. Build the NP workforce, including a focus on end-to-end rural education opportunities and development of generalist nursing scope of practice.

6. RACCHOs be considered as a holistic mechanism for growing the NP contribution to the health care system rurally, addressing numerous barriers and facilitating enablers to practice.

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National Rural Health Alliance Members (December 2021)

Organisations with an interest in rural health and representing service providers and consumers

Allied Health Professions Australia (Rural and Remote Committee)	Exercise & Sports Science Australia
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)	Federation of Rural Australian Medical Educators
Australasian College of Health Service Management (Regional, Rural and Remote Special Interest Group)	Isolated Children's Parents' Association
Australasian College of Paramedicine	National Aboriginal Community Controlled Health Organisation
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
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Australian College of Midwives (Rural and Remote Advisory Committee)	Optometry Australia (Rural Optometry Group)
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Australian College of Rural and Remote Medicine	Royal Australasian College of Medical Administrators
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Australian Indigenous Doctors' Association	Royal Australian College of General Practitioners (Rural Faculty)
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Australian Paediatric Society	Royal Flying Doctor Service
Australian Physiotherapy Association (Rural Advisory Council)	Rural Doctors Association of Australia
Australian Psychological Society (Rural and Remote Psychology Interest Group)	Rural Health Workforce Australia
Australian Rural Health Education Network	Rural Pharmacists Australia
Council of Ambulance Authorities	Services for Australian Rural and Remote Allied Health
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	Society of Hospital Pharmacists of Australia
CRANAplus	Speech Pathology Australia (Rural and Remote Member Community)