Submission by the Australian Nursing and Midwifery Federation

Australian Government public consultation Unleashing the potential of our workforce – Scope of Practice Review

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Australian Nursing & Midwifery Federation

Australian Nursing and Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 322,000 nurses, midwives and carers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best-practice care in every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems and the health of our national and global communities.

5. The ANMF welcomes the opportunity to provide feedback to the Australian Government's Independent Scope of Practice Review. The response considers the nursing and midwifery workforce across Australia and its role in primary healthcare. Nurses and midwives already lead in the primary healthcare setting, working with communities, identifying needs, and implementing services. However, the scope of practice of nurses and midwives has been restricted by current approaches to healthcare funding and policy, service provision as well as the requirement for collaborative arrangements. People in Australian communities are feeling the result of this constraint through a shortage of primary healthcare providers. If able to work to and expand their scope of practice, nurses and midwives will increase the number of primary healthcare providers to give the public a choice and improve access to affordable and appropriate healthcare that is driven by the human right to healthcare, not profit.

6. The Australian Government has a responsibility to ensure all people living in Australia have equitable access to affordable primary healthcare. Nurses and midwives have the education, skill and experience

to do this if they are supported to work to their scope of practice. The NMBA define the scope of practice for nurses and midwives and suggests that,

> *While the foundational education of RNs, ENs, NPs and midwives in Australia captures the full breadth of the scope of the profession at the graduate entry level, the scope of practice of individual practitioners is influenced by the settings in which they practise. This includes the health needs of people, the level of competence and confidence of the nurse or midwife and the policy requirements of the service provider. As the nurse or midwife gains new skills and knowledge, their individual scope of practice changes.*[1]

Survey questions

About you

7. The ANMF seeks to ensure that nurses and midwives are supported to work to and expand their scope of practice to allow equitable access to safe and affordable primary healthcare for all people living in Australia. This submission will respond to the survey questions and provide several examples of nurse and midwife-led care in the setting of the multidisciplinary team.

Primary health care

8. Primary health care is a whole-of-society approach to health. It aims at ensuring the highest possible level of health and wellbeing and its equitable distribution by focusing on people's needs as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment.[2]

9. Primary health care utilises a holistic, biopsychosocial perspective of health that recognises the interconnection of relationships, work, the environment, and social determinants of health. Primary health care promotes the concept of self-reliance and strength to individuals and communities in exercising control over conditions that determine their health and play an integral role in both preventive and public health.[3] No one profession should be responsible for or seek to address all areas of healthcare provision. Medical practitioners have become the gatekeepers of access to primary healthcare, and this needs revision, so every Australian has access to and receives appropriate and affordable care.

Context

10. Nurses and midwives comprise the single largest professional group within health care and practice across all sectors, in all geographical regions, at defined levels of scope. For nurses, these levels include the registered nurse (RN), the enrolled nurse (EN), and the nurse practitioner (NP). For midwives, these levels include midwives and endorsed midwives (EM).

Nurses and midwives in Australia

11. Data from the NMBA shows that in 2023, 440,110 nurses in Australia held general registration. This comprised of 68,573 ENs, 360,108 RNs and 11,429 with dual registration.[4] In June 2023 there were a total of 25,645 midwives, including 25,437 registered as RN/midwife, 105 registered as EN/midwife and 103 practitioners registered as EN/RN/midwife. Additionally, there were 7,410 midwives with single registration.[5] These figures demonstrate nursing and midwifery to be the largest workforce in the country. However, it must be noted that many nurses and midwives are not currently in the workforce. In October 2022, although 448,129 nurses and midwives were registered, only 372,759 were currently employed. The reasons for this must be explored.

12. In June 2023 there was 2,656 NPs in Australia and 1,258 RNs with scheduled medicines – rural and isolated practice endorsement. Disappointingly, 2022 figures show that of the NPs, 539 were not working as nurse practitioners.[6] Reports from ANMF members suggest this is because NP positions did not exist, highlighting a major lost opportunity. Members also report the lack of career progression available to NPs, resulted in a number moving to managerial positions where they can progress professionally and access higher remuneration. 1,089 midwives in Australia, held scheduled medicines endorsement and there was one midwife practitioner listed.[7] These figures represent a huge workforce with the potential to transform primary healthcare access and delivery.

13. To register with the NMBA, RNs must complete an NMBA approved entry to practice qualification or equivalent (either a bachelor's degree, AQF 7 or a master's degree, AQF 9). ENs complete an NMBA approved Diploma of Nursing or equivalent (AQF 6). Midwifery is a separate profession and includes midwives and endorsed midwives (EM). To register as a midwife, a person must complete either a direct entry Board approved program of study or a postgraduate diploma in midwifery available to registered nurses.

14. EMs and NPs practice at advanced levels and meet criteria and practice standards. Criteria for endorsement as an NP includes completion of an NMBA approved specialist postgraduate qualification (Master or Doctoral level), extensive clinical experience at advanced levels and meeting the relevant practice standards set by the NMBA and AHPRA.[8] An EM has met the requirements of the NMBA registration standard: Endorsement for scheduled medicines for midwives and is qualified to prescribe scheduled medicines and provide associated services required for midwifery practice in accordance with the relevant state and territory legislation.[9]

15. In Australia, other nurses and midwives work at advanced practice levels in a particular context, for example, clinical nurse specialist (or level 2), clinical nurse consultant (or level 3), clinical midwife specialist (or level 2) and clinical midwife consultant (or level 3). These nurses and midwives usually hold postgraduate qualifications with a significant amount of clinical experience at advanced levels in their area of practice. Advanced practice roles attract higher remuneration to reflect the increased level of knowledge, education, and responsibility.

16. To remain registered, all nurses and midwives must continue to demonstrate to the NMBA and AHPRA that they engage in professional development and are current in their practice.

Access to primary health care

17. Access to primary healthcare has become increasingly difficult as medical practitioners choose to work in areas other than general practice, [10] and out-of-pocket costs to visit a general practitioner spiral.[11] The Australian Medical Association (AMA) suggests the demand for GPs has risen over time. Still, supply has yet to keep up, especially in rural and remote communities, with the AMA predicting a shortfall of 10600 GPs by 2031-2032. [12] However, many communities, such as rural areas, are already experiencing this gap,[13] and despite large financial incentives, recruitment and retention of GPs has not grown,[14] resulting in poorer health outcomes and patient experiences and reduced or delayed access to primary healthcare with subsequent increased burden on other health services such as emergency departments (ED).[15] Central to this deficit has been the establishment of GPs as the gatekeepers of primary healthcare and access to funding, with other practitioners locked out of providing the full scope of primary healthcare services as autonomous practitioners and as members of multidisciplinary teams. For example, nurses working in GP practices must be supervised by a medical practitioner. They work to a restricted scope of practice comprising activities related to specific MBS items that the GP can claim. Changes to legislation,

as well as jurisdictional and organisational policy reforms, are required, together with the need to raise public awareness about how nurses and midwives can offer a safe and affordable choice of primary health practitioner.

Funding reform

18. Reform to primary healthcare funding is urgently needed. Currently, in most cases, people must pay to see a GP and to access other services, including diagnostic testing. NPs can order certain tests, but rebates for these are restricted. For example, Jo Perks has been working as an NP in women's health since 2005. Women visit Ms Perks for many reasons, including her vast experience in the area, but also due to cultural or social reasons. Many do not feel comfortable speaking about sexual health with a male GP. Ms Perks, however, is still unable to order a mammogram or pelvic scan under the medical benefits scheme (MBS). If referred by Ms Perks, the woman would need to pay full fees. For a woman to access this service under the MBS, she must visit a GP, which means undertaking another trip to a health provider and often incurring out-of-pocket costs.

19. Janet, an endorsed midwife, sees many women in her private practice. However, she is not permitted to order routine ultrasounds or pathology despite her education and experience in interpreting results. Instead, she must refer women to a GP for these assessments, fragmenting care delivery and increasing fees to access healthcare for women.

20. Most general practitioner practices use profit-driven, fee-for-service models subsidised by governments through Medicare. This approach has resulted in the privatisation of primary healthcare. Groups representing GPs, such as the AMA, demand increasing amounts of government funding to support GP businesses, with the person seeking primary healthcare making up the difference through out-of-pocket costs (on top of their Medicare levy). These demands have held governments to ransom and undermined attempts to uphold a system of universal healthcare.

21. Primary healthcare, like aged care and the NDIS, has seen an increasing trend to outsource to private providers and unregulated workers while at the same time depleting the public service. This has limited the ability to make sure workers are safe at work and providers accountable. The Royal Commission into Aged Care concluded that market-based approaches to the provision of public goods and services such as health and aged care has and will continue to fail. Privatisation has failed and is not the solution,

therefore the model must change. Healthcare must be seen as a human right, not a business driven by profits. Primary health care funding must move away from fee-for-service and outsourcing, toward block funding or blended models, where health practitioners work autonomously but collaboratively for a wage in publicly funded and administered models of care. The Strengthening Medicare Taskforce recommended encouraging multidisciplinary team-based care[16] such as that seen in federally funded National Aboriginal Community Controlled Health Organisation (NACCHO), the jurisdictionally funded Walk in Centres in the ACT. Federal, state and territory governments must also consider strengthening and reinvigorating Community Health Centres to provide access to multidisciplinary teams and a choice of autonomous provider for primary health care.

1. Which of the following perspectives best describes your interest in the Scope of Practice Review?

- o Aboriginal and Torres Strait Islander health practitioner
- o Aboriginal and Torres Strait Islander health worker
- o Allied health
- o Consumer
- o Government
- o Health administration
- o Insurer
- o Medical – GP
- o Medical – other specialty
- ✓ Midwife
- ✓ Nursing – enrolled nurse
- ✓ Nursing – nurse practitioner
- ✓ Nursing – registered nurse
- ✓ Peak Body
- o Paramedic
- o Pharmacy
- o Practice manager
- ✓ Professional association
- o Regulator
- o Student

- ✓ Other

Other role: National Union

2. What is your postcode?

3000

Benefits of expanded scope of practice

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

- Consumers ☑
- Funders ☑
- Health practitioners ☑
- Employers ☑
- Government/s ☑
- Other ☑

Other group(s): Occupational health and safety groups, Industrial groups and nursing education

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

22. Many groups would benefit from nurses and midwives working to and expanding their scope of practice, including nurses and midwives themselves, people seeking primary health care, governments funding primary and other levels of health care, and employers. The following section will expand on these groups.

Nurses and midwives

23. Nurses and midwives provide holistic care using a person or woman-centred framework. Nurses and midwives are expected to meet the standards for clinical practice for their profession and to work autonomously and collaboratively as members of multidisciplinary teams. Working to, and expanding their scope of practice by incorporating new areas of clinical work and education presents nurses and

midwives with the opportunity of expanded career trajectories, increased job satisfaction and decreased burnout and attrition.[17]

24. Nurses and midwives are already leading care and undertaking evidence-based, person-centred care in their local communities. However, this is not widespread, nationally consistent or supported by secure funding and policy.

25. In addition, NPs and EMs have been constrained by the requirement to work in a collaborative arrangement with a medical practitioner. The ANMF notes that following announcements in the 2023 federal budget, the requirement for NPs to enter into collaborative arrangements will be removed.[18] However, NPs, may remain subject to further restrictions as a result of jurisdictional or organisational policies that constrain their practice despite their education and experience.

26. Australian and international nurse and midwife-led models of care are cost-efficient with positive health outcomes and represent effective, feasible and appropriate ways of delivering care.[19] Publicly funded midwifery-led continuity of care models cost 22% less than standard models of care, in addition to offering reduced rates of foetal and neonatal loss, birth intervention, and premature birth. Despite the substantial cost savings, in 2022, only 14% of care models fell into the category of midwifery group practice caseload care.[20] [21]

27. Evidence suggests that NPs deliver health outcomes at least equivalent to those delivered by medical practitioners for people with chronic health conditions in primary care. Further, nurse-led care has been found to be more effective than medical care in promoting adherence to treatment and patient satisfaction.[22] [23] US studies conclude that NPs working independently (that is, without the requirement to be supervised by a medical practitioner) increase the number of primary care providers, improve the frequency of routine checkups and quality of care and decrease emergency department presentations by patients with ongoing health conditions.[24] NPs and advanced practice nurses (APN) have direct and indirect cost savings and positively impact the quality of life for people seeking healthcare. For example, nurse-led Walk in Centres (WiC), introduced to the ACT in 2012 was a major initiative of the territory government, demonstrate significant improvements in the delivery of primary health care.

28. The WiCs are based on a model developed in the United Kingdom (UK). The 5 WiCs are situated in population centres across the ACT. They employ a team of APNs and NPs and are well supported by the communities they serve, increasing access to free primary health care. The model has improved the retention of the nursing workforce by supporting many of them to work to their scope of practice in the clinics, resulting in improved work satisfaction.[25] Close collaboration and consultation exist between the WiC administration and consumers, the community, the hospital administration, the ACT Ambulance Service, and many local GPs. Data from the WiCs in 2022 report that WiC nurses saw 20,552 presentations and tested 26,766 people for COVID-19 with a median wait time of 29 minutes.[26] Nurses redirect patients to other health providers as appropriate. Community acceptance is high, and since 2021, the WiCs saw an increase of 48.1% in presentations. Of those seen, 81.2% received treatment at the WiC and 5.9% were redirected to the ED, with the remainder redirected to a general practitioner or leaving without being seen.[27] These figures represent a significant number of people diverted from ED, resulting in cost savings for hospitals, the government and people seeking primary health care, as well as reduced waiting times and pressure on GPs. These hubs offer further opportunities for practitioners to work to their full or expanded scope. They could also extend to include co-located practitioners or the establishment of midwifery group practices.

Communities and individuals

29. Communities and individuals benefit from improved access to nurse and midwifery-led primary health care services as well as the choice and number of other primary care practitioners. Advanced practice nursing models embedded within the multidisciplinary team and where APNs work collaboratively and to their full scope of practice facilitate access to each professional group. Such models enhance coordination and transitions of care and reduce the duplication of services. Community members are offered their choice of practitioner to provide them with holistic healthcare, assessment, and case management, supported through block funding (or similar) models.

30. Examples include, vaccination clinics and services utilised during the COVID-19 pandemic. Nurses and midwives were at the forefront of running vaccination clinics and ensuring people had access to and received vaccinations. Infection prevention nurses promoted healthy ways of living and working to ensure the community remained as safe as possible and minimised infection spread. Child and family nurses (however titled, for example, maternal child health nurses in Victoria), who lead care that offers

families in the local community free access to highly skilled nurses and midwives for advice, assessment, screening, monitoring, education, infant vaccination clinics and more, leading to improved access and outcomes for parents and children.

31. Women and babies experience better outcomes when a known midwife and caseload or midwifery group practice (MGP) is used. These models are more cost-effective and offer improved outcomes for women, resulting in significantly higher rates of normal birth compared to standard hospital care and private obstetric care.[28] Added to improved outcomes, MGPs demonstrate cost savings for health departments due to reduced intervention and hospital stays. MGPs were shown to cost 22% ($5,208) less per pregnancy than other models of maternity care.[29] In the public sector, endorsed midwives working to their scope of practice would be able to prescribe and order diagnostic tests, reducing medical practitioner workloads. Increasing the number of privately practicing midwives in the community would reduce the cost burden on public hospitals and offer women another choice of practitioner.

32. The NSW Ministry of Health Framework, the *First 2000 days, conception to age 5*, Objective 2 states that the health system *provides care to all and works in partnership to promote health, wellbeing, capacity, and resilience during the first 2000 days.* Incorporating MGPs into primary health centres and with midwives working with other health practitioners as peers, not prefects, would help to improve communication and continuity of care by presenting a one-stop shop for women and their families that could be accessed from adolescence through pregnancy and as their children grow. Incorporating services such as midwifery, child and family health nurses, women's health nurses (however titled), mental health clinicians, and other specialty roles would help to do this. Such a service would also help prevent women and families from falling through the gap and encourage greater community engagement and support.

33. NPs and EMs practice both autonomously and collaboratively with other health professionals to improve access to healthcare for Australian communities through health promotion, disease prevention, and health management strategies. It is within an NP's ability to assess and diagnose health problems, order and interpret diagnostic investigations, formulate and assess responses to treatment plans, prescribe medicines and refer to other health professionals within their areas of competence. Nurse practitioners may also admit and discharge people from health services, including hospital settings. They improve health outcomes for specific patient populations or communities. However, NPs have been unable to

work to their scope of practice due to the requirement for collaborative arrangements with medical practitioners, limiting their ability to deliver primary healthcare equitably. In Australia, legislative changes are underway to remove this requirement. It is hoped that jurisdictions will acknowledge and support the changes, and the unfounded campaigns attempting to discredit nurses and midwives will be disregarded.[30] [31] Nurses and midwives must be able to work to their scope of practice unimpeded.

Governments and costs

34. The burden placed on emergency departments (ED) to provide primary healthcare continues to increase, often because of avoidable, non-urgent or inappropriate presentations and exacerbated by people's inability to access primary healthcare in the community setting.[32] Increasing the primary healthcare workforce offers the opportunity to reduce the number of presentations to EDs, enabling the ED workforce to focus on patients in critical conditions and reduce ramping and waiting times and costs to the health service. The WiC in the ACT described earlier provides an example of one way this might occur, as do health services for people experiencing homelessness.

35. People experiencing homelessness have significantly greater health needs than the general population, accounting for a disproportionate use of acute health services and emergency department presentations. Not only is this expensive, but due to the very nature of EDs, the care available to this group is often inappropriate and lacking in coordination.[33] There are many reasons why people experiencing homelessness disengage from traditional primary healthcare providers, including lack of trust and cost of services in an increasingly privatised context and stigmatisation.

36. A Co-located nurse-led primary health clinic run within a hostel in inner Sydney for men experiencing or at risk of experiencing homelessness is an example of a service set up due to needs identified by the nurses working in that community.[34] The service offers medical and mental health assessments, diabetes management, medicines administration and monitoring of efficacy and side effects, facilitation of prescription dispensing, and case management for those with more complex needs. Other services at the clinic include a medical practice, specialised preventative management programs, optometry, and podiatry care.[35] Clinics such as these for those experiencing homelessness reduce avoidable or inappropriate hospital ED presentations by adopting and promoting preventative care, early intervention, and coordination of services in a safe and trusted environment with nurses providing case management and continuity.

37. Increasing the number of independent primary healthcare practitioners, who can deliver the full range of primary health care services presents a positive step toward achieving equitable access and universal healthcare coverage for all people living in Australia.

Risks and challenges

5. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?

38. There are few risks to the public, from nurses and midwives working to or extending their scope of practice. However, there are considerable risks for nurses and midwives which are outlined below.

Confusion about the definition of scope of practice

39. Downie, Walsh, et al. found a need for more consistency regarding the definition of the scope of practice across health professions in Australia, suggesting the lack of definition has led to complexity and, thus, confusion regarding which profession does what. [36] Such confusion may be part of the reason different jurisdictions or organisations produce policies restricting nurses and midwives from working to their scope of practice. For example, enrolled nurses in some metropolitan areas have provided examples of restrictions on their practice that stop them from administering insulin, attending to complex wound dressings, attending central line care, and checking Schedule 8 medications, despite this being within their scope of practice and education. This situation has left ENs feeling deskilled and unable to do what they are educated to do.[37]

40. Another example is that of a registered nurse working as part of the venous access team at a large metropolitan hospital who wanted to expand his scope of practice to include central venous line insertion. He was told that the hospital would not support this expansion of the role due to their insurance policy, despite other registered nurses performing this procedure across NSW and realising the associated benefits, including freeing up medical staff for other duties. Too often, decision makers and those writing workforce policies lack understanding of the scope of each discipline working in their facilities and seek to simplify their processes by using blanket policies, resulting in restrictions to practice.

41. Leadership from federal and state/territory governments is needed to ensure national consistency. Reform is required at local levels to ensure health services have policies and procedures in place that are

up to date and supported by contemporary evidence, including for example, the NMBA's Decision-Making Framework for nursing and midwifery practice. The examples above highlight the need for scope of practice reform to include associated education for employers of nurses and midwives to ensure that they are up to date with research, legislation, professional standards and best practice models.

42. Expanding the scope of practice and capabilities of nurses and midwives must include a commitment from employers of nurses and midwives to develop, implement, review and refine local policies and practices so nurses and midwives working in Australia can work to the full scope of their current practice in accordance with their educational preparation, experience and NMBA authorisation and decision-making frameworks for nursing and midwifery practice.[38]

Industrial considerations

43. Industrial risks must be considered. Where a nurse or midwife's scope of practice expands, remuneration must reflect the necessary increase in skill, education, and responsibilities. Professional indemnity insurance (PII) must also be expanded to include current and future cover for any redefined and emerging scopes of practice.

Lack of support and fear campaigns

44. Nurses and midwives working to their scope of practice, especially in nurse-led and midwife-led services, risk criticism, false claims, and a lack of support from some employing organisations that do not support nurses and midwives to work autonomously or as part of multidisciplinary teams (MDT) to deliver primary healthcare.[39] Both national and jurisdictional governments must be seen to support nurses and midwives working to their scope of practice through public education campaigns, as well as embedding nationally agreed policies and guidelines across the country. Certain groups in society have actively sought to discredit nurses and midwives working at advanced levels by making unfounded claims and suggesting their practice is or would be unsafe. Such behaviour and conduct must be called out as lies, innuendo and unprofessional.

Use of language and terminology

45. The use of language in the public domain by governments and organisations is an important consideration. Primary healthcare is provided by nurses and midwives, not only general practitioners. Where primary healthcare is being offered, people should have the opportunity to be referred to the

appropriate healthcare practitioner, so they receive the right care at the right time and avoid duplication of services and fees.

46. Primary health care practice is not solely the domain of medical practitioners. More generic and inclusive terms, such as primary healthcare practitioner, which recognises all relevant health professionals, should be used. This change will help the public begin to understand that they have choices about which primary healthcare practitioner they can access.

Lack of resources and insecure funding for alternative models of care

47. Nurses and midwives often set up primary care programs based on their experience and observations working directly with communities. Such services require time to develop. However, insecure, short-term funding, together with limited access to informatics and research skills, restricts the way results are collected and reported, which is particularly challenging for services run with small numbers of practitioners in small communities or addressing needs in emerging situations.

48. For example, a community health service wanted to offer free vaccinations to Aboriginal and Torres Strait Islander children and families living in rural communities. No funding was available to pay for additional nursing or midwifery staff qualified to administer vaccinations. The Nurse Manager reorganised staffing so two nurses could cover the four clinics. This decision meant other services were left short of nurses, but everyone agreed it was a priority. Given the thin spread of resources and staff, there was limited time and funds to find people to follow up with the families and to collate, analyse and report on the data and outcomes of the clinic. Despite its success and likely downstream cost savings, funding was not made available for future clinics, making it unsustainable. Having people skilled in setting up, analysing, and reporting on data could have made the difference in accessing funding and improving vaccination rates for this population.

Status quo

49. The greatest risk to primary healthcare and community access will be that everything stays the same, and profit-based models of primary healthcare, controlled by medical practitioners and other private providers, prevail as the accepted norm. Such models will result in increased government spending to support private business models with increased out-of-pocket costs for people seeking health care. Additionally, vulnerable, and high-risk groups may choose not to seek primary care, such as those experiencing homelessness, as mentioned earlier, resulting in increased presentations to the ED or use

of other emergency services, such as Ambulance, due to health deterioration from a lack of assessment, monitoring and early intervention. Further, the constraints placed on the scopes of practice of nurses and midwives may result in increasing attrition rates, adding to workforce shortages and further limiting access to primary healthcare.

6. Please give any evidence (literature references and links) you are aware of that supports your views.

The literature supports nurses and midwives working to, and expanding their scope of practice and highlights the impacts on nurses, midwives, and communities if the current status quo is perpetuated.

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Scope of practice issues confronting ENs
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Traczynski, J. and V. Udalova (2018). "Nurse practitioner independence, health care utilisation, and health outcomes." Journal of health economics 58: 90-109.

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Positive outcomes associated with midwifery group practice
Watkins, V., et al. (2023). "The role and scope of contemporary midwifery practice in Australia: A scoping review of the literature." Women and Birth.

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Callander, E. J., et al. (2021). "Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery." International Journal for Quality in Health Care 33(2): mzab084.

Enhanced scope of practice improves primary healthcare capacity
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Expanding scope of practice does not negatively impact patient outcomes
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Coster, S., et al. (2018). "What is the impact of professional nursing on patients' outcomes globally? An overview of research evidence." International Journal of Nursing Studies 78: 76-83.

Optimising scope of practice for nurses enhances care for people experiencing homelessness
Kandrack R, Barnes H, Martsolf GR. Nurse Practitioner Scope of Practice Regulations and Nurse Practitioner Supply. Med Care Res Rev. 2021 Jun;78(3):208-217. doi: 10.1177/1077558719888424. Epub 2019 Nov 15. PMID: 31729899.

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Mainey L, O, Mullan C, Reid-Searl K, Taylor A, Baird K. The role of nurses and midwives in the provision of abortion care: a scoping review. Journal of clinical nursing. 2020 May;29(9-10):1513-26.

Limited scope of practice is detrimental to health disparities and inequity
Xue Y, Ye Z, Brewer C, Spetz J. Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systematic review. Nurs Outlook. 2016 Jan-Feb;64(1):71-85. doi: 10.1016/j.outlook.2015.08.005. Epub 2015 Sep 9. PMID: 26475528.

Real life examples

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

- No
- Yes☑

50. Nurses and midwives always work as part of interdisciplinary and multidisciplinary teams. This approach is integral to their education and embedded within their standards for practice. They are educated to

work collaboratively and autonomously and to advocate for people who need varying levels of care and assistance in their lives.

51. There are hundreds, probably thousands of examples of nurse and midwife-led care, too many to mention here. Below is a select number of nurse and midwife-led models of care, where nurses and midwives work to their scope of practice but where, in most cases, an expansion to that scope would not only be appropriate but improve the services delivered. The practitioners and services listed in the examples in question 8 are innovative and responsive to need. Often, this work is done quietly and quickly because the need is urgent.

8. Please give examples and any evidence (literature references and links) you have to support your example.

52. The following offers a small sample of the nurse and midwife-led services and multidisciplinary teams that exist in communities across Australia. Links have been provided and offer additional information.

53. The highlighted services have been established in response to community needs, often identified by nurses and midwives, and supported through local community and healthcare networks. The nurse and midwife-led services demonstrate the geographical spread of where nurses and midwives live and work, the depth of their knowledge and the breadth of the specialty and generalist services they provide. Nurses and midwives would be better able to deliver holistic and comprehensive care in most of these services if supported and funded to work to and expand their scope of practice working autonomously and with other practitioners especially if offered the resources to conduct research to track and highlight the service's work.

Rural midwives

54. Rural midwives working in Primary Healthcare are the best examples of midwives working to their full scope of practice. Rural midwives provide holistic care that ranges from routine antenatal, intrapartum, and postnatal care to case management scenarios where midwives locate accommodation for families, liaise with specialists remotely and provide emergency and high-risk midwifery care as needed. This scenario is outlined in the National Consensus Framework for Maternity Services.
55. Midwifery group practice is an example of midwives working to their full scope of practice. Midwife-led continuity of care models benefit women, midwives, and health departments. This model is safe but

requires greater funding to support research to ensure it is sustainable. Jurisdictional disparities in remuneration may serve as a barrier to recruiting midwives; for example, the NSW award for those working in MGPs is significantly lower compared to other states.

Midwifery Group Practice

56. *Dhelkaya Health*, meaning 'baby health', is a woman-centred, culturally safe, and collaborative model of care that offers women three care pathways depending on their needs – midwifery group practice, collaborative shared care, and complex maternity care. https://anmj.org.au/call-on-me-how-midwifery-continuity-of-care-is-improving-outcomes-for-women-and-babies/

ACT Walk-in Centres

57. *Advanced practice nurses caring for communities in need.* ACT Walk in Centres were discussed earlier and are nurse-led, offering free primary health care to the community. https://anmj.org.au/advanced-practice-nurses-caring-for-communities-in-need/ and https://anmj.org.au/leading-the-way-how-nurse-led-models-of-care-are-reshaping-healthcare-walk-in-centre-kirsten-madsen/

Women's Health

58. *Nurse Practitioners Barriers to Practice.* Jo Perks is an NP working in Women's Health and providing services to women, including those from vulnerable backgrounds. Jo identifies the ongoing barriers to providing holistic care, such as the inability to order diagnostics, which means clients must see a GP and pay the associated out-of-pocket costs. https://anmj.org.au/nurse-practitioners-barriers-to-practice/

Aged Care

59. *How nurse-led models of care are reshaping healthcare – Aged Care. NP Hazel Bucher*. Hazel Bucher works as an NP, providing care to aged care residents as well as running a nurse-led memory clinic. While she has worked in shared models of care, she believes a standalone NP-led model of care, such as those in New Zealand, would better meet the needs of vulnerable older Australians. https://anmj.org.au/leading-the-way-how-nurse-led-models-of-care-are-reshaping-healthcare-shared-care-model-hazel-bucher/

Gender affirming primary care

60. *Nurse Practitioners and gender-affirming primary care clinics for transgender and gender diverse people*. This article describes an NP-led transgender and gender diverse clinic for people aged 18 years and over, run at the South Australian City West Health Clinic at the University of South Australia.

https://anmj.org.au/nurse-practitioners-and-gender-affirming-primary-care-clinics-for-transgender-and-gender-diverse-people/

Teen Clinic

61. *How nurse-led models of care are reshaping healthcare – Bega Valley Teen Clinic*. The early intervention, nurse-led model of care gives teens access to registered nurses where they can discuss issues affecting them. The nurses also facilitate visits with GPs and other healthcare professionals. https://anmj.org.au/leading-the-way-how-nurse-led-models-of-care-are-reshaping-healthcare-bega-valley-teen-clinic-meghan-campbell/

Nurse-led care and multidisciplinary teams for homeless populations

62. Life expectancy gaps of more than 30 years among people who are homeless have been reported in the UK, US, and Australia, with mortality rates around ten times higher than that of the general population in wealthy countries. Morbidity is also higher, with numerous physical and mental health conditions exacerbated by multimorbidity. This population is often disengaged from primary healthcare services for many reasons, including the cost of services, lack of requisite identification, fear and mistrust and stigmatisation. This situation often results in presentations to emergency departments that could have been prevented with early intervention and case management.[40] Three services are described below, but many areas in Australia need such services.

- Homeless Health Care Western Australia (WA) provides primary healthcare and support to people who are homeless, including after-hours support, mobile services, and street health in-reach. These services could be nurse-led, with the ability to refer people to other health practitioners if needed.
- The Homeless Health Service at St Vincent's Hospital Sydney is a multidisciplinary outreach team of clinical and non-clinical staff, including nurses, allied health, medical practitioners, peer workers, Aboriginal health workers and counsellors. The unit delivers services to the homeless population, such as vital healthcare, help navigating the health system, and links to additional support. The community health outreach team runs clinics in places where homeless people typically congregate, like drop-in-centres, hostels or churches.
- Homeless Health Outreach Team (HHOT) | Gold Coast Health provides comprehensive assessments, care coordination and clinical interventions for homeless persons in the community who are experiencing mental illness.

Virtual community care and monitoring

63. Virtual care has existed for some time, but its use was fully realised across the world during the COVID-19 pandemic, and it is becoming a part of routine care.[41] In 2020, NSW Health introduced a nurse-led virtual clinic for people diagnosed with COVID-19 so they could isolate at home while their symptoms were monitored. They had access to virtual advice and follow-up from RNs 24 hours per day. Monitoring equipment and digital devices were supplied through the local health service. Observations were recorded via Bluetooth to secure cloud storage, which the multidisciplinary team could access. Nurses worked remotely and scheduled visits to each person via videoconferencing or if the person's observations indicated deterioration or they self-reported worsening symptoms. Nurses with specialist knowledge, such as child and family nurses or midwives, were available where needed. A rostered visiting medical officer was available for medical advice and prescribing and was involved in the twice-daily (at least) online case discussions. The team worked closely with the paramedic teams, who could be called upon to collect pathology samples and conduct more in-depth, in-person assessments and escalate if required. A similar approach could be expanded to managing and monitoring people with chronic illnesses and multimorbidity living in the community, particularly if RNs' scope expanded to include electronically prescribing stable, routine medicines for people at home in consultation with their NP or GP.

Nurse-led models in palliative care

64. Nurse-led models of palliative care have been implemented in rural and metropolitan areas across private and public sectors to provide person and community-centred care. Services differ depending on location, funding, and community needs. The Sydney Adventist Hospital runs a philanthropically funded NP-led palliative care outreach service that provides 24-hour care and consultation for those receiving treatment/care through the hospital.[42]

65. In Southern NSW, specialist palliative care teams are led by NPs who work across inpatient, outpatient and community settings. This positioning allows easy referral and access to clinical and allied health care. The services are block-funded through State and Commonwealth funding. The presence of a palliative care NP means that people can readily access expert, individualised assessment and treatment without the need for hospital admission. This model is particularly effective where medical coverage is limited or palliative care knowledge is low. The NPs in this model lead a team of registered nurses who collaborate

with community nurses, GPs, remote specialist services and inpatient units to provide outreach and in-reach, optimising transitions and continuity of care.

School nurses

66. *School nurses – the secret superheroes*. In Australia, over 1,500 nurses and midwives work across education sectors in public and independent schools and broad geographical settings. They work collaboratively with teachers, families, and communities to provide primary healthcare to school populations. School nurses work across age groups, from preschool to tertiary level, including special developmental schools, identifying and responding to a broad range of issues that children and adolescent's encounter. The work encompasses education, health promotion, preventative health, screening, vaccination and planning early intervention strategies.

67. Increasing the number of school nurses across Australia offers many advantages for nurses already embedded in healthcare and working with the school community. This approach results in integrated care and communication between schools and health networks. Students often identify nurses as trusted school community members and safe people to disclose personal and private information.

Recovery camp

68. A nurse-led initiative for people with lived experience of mental illness and students studying health, including nursing. Each camp is a four-night, five-day immersive experience where health students and clinicians from a range of disciplines and people with lived experience of mental illness engage together in recovery-oriented, therapeutic recreation activities that promote mental health, social connection, and physical activity. Research is also embedded into the program. In 2023, the group ran their 40th camp. https://www.recoverycamp.com.au/recovery-camp/

Facilitating best practice

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

Please provide references and links to any literature or other evidence.

69. There are several barriers that government, employers, and regulators can address.

Removal of jurisdictional and organisational boundaries

70. Identifying ways to remove jurisdictional and organisational barriers that limit the scope of practice of nurses and midwives is essential. Advanced practice roles provide alternatives to improve care by increasing the number of primary healthcare providers, especially where there is increased demand for services. Supporting nurses and midwives to work to the full scope of their education is often constrained by culture, education, regulatory issues, institutional issues, and professional practice boundary issues [43] and should be addressed.

71. As mentioned earlier, in several instances, organisational policies restrict nurses and midwives in their practice. A national workforce standard/policy enabling nurses and midwives to work to an NMBA scope of practice that overrides organisational particularities is needed. This would allow practitioners to move to other positions, knowing they will be able to work to their scope of practice. It also reduces confusion among employers who are trying to understand multiple scopes of practice across disciplines.

72. Currently, policies differ from hospital to hospital, state to state and present a barrier to midwives working to their full scope of practice. National policies supporting midwives to work to their full scope in MGP and other continuity of care models would help to improve morale amongst midwives who feel disillusioned by current systems and their inability to work to their full scope of practice. It would also assist in alleviating financial pressures by reducing the burden experienced through hospital-based approaches to midwifery care. Endorsed midwives are currently unable to use their skills in the public system. This barrier is preventing endorsed midwives from working to their full scope. Allowing midwives to order diagnostic tests and prescribe medications would relieve the stress placed on medical staff and reduce costs to the hospital.

Industrial considerations

73. Governments, jurisdictions, regulators, organisations, and unions must work together to ensure that increased responsibilities associated with an expanded scope of practice are reflected through wages and conditions and that PII covers any expansion to the scope of practice.

Resolve jurisdictional pay inequities

74. The inequitable pay between jurisdictions presents a barrier for those working in the MGP. Although MGPs offer flexibility to midwives, part-time modes of employment need to be developed and implemented to help sustain the model and prevent staff burnout. This inequity in pay also occurs for

nurses. For example, the pay for child and family nurses in NSW is far less than for those working in the ACT. In NSW, child and family nurses are paid as RNs despite requiring a postgraduate qualification. In the ACT, child and family nurses are paid as CNS (level 2) or CNC (level 3).

Resolve MBS and PBS constraints

75. The current funding restraints in accessing the MBS and PBS by nurses and midwives impact their ability to work to their full scope of practice in the community.

Support designated RN nurse prescribers

76. Expand the scope of practice for RNs, allowing endorsement as a designated registered nurse prescriber as set out in the AHPRA Consultation regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber, which ran from 16 June – 28 July 2023.

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

Funding reform

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

Fund midwifery group practices and midwife-led continuity models of care

78. This funding will improve health outcomes for women and their babies and decrease costs to the health system.

Increase primary healthcare theory, simulation and workplace learning in pre-registration nursing and midwifery education programs

79. Australia must focus on developing and expanding the capacity to deliver primary healthcare and educating the workforce to support it. Primary healthcare must be viewed and supported by more than

just general practitioners and include areas such as mental health services, palliative care, women's and sexual health, wound care, diabetes care, health promotion, vaccination, school nursing and so on.

80. Meeting the future workforce requirements of the primary healthcare sector must continue to be considered, including pre-registration education for nurses and midwives. Education providers should consider increasing the content and variety of primary healthcare theory, simulation and quality workplace learning experiences. Students should be exposed to the broad context of primary healthcare in the community through quality and supported practicum.

Resource provision for evaluation and planning of nurse and midwife-led services

81. As described earlier, resource provision and funding are major barriers to the sustainability of nurse and midwife-led services. Often, this relates to a need for more knowledge or time to plan, collect, analyse, and interpret data to demonstrate outcomes of services and inform funding applications. This situation could be addressed in 2 ways.
    - Providing resources to assist nurses and midwives in evaluating, planning, collecting, analysing, interpreting, and reporting on service data to support funding applications.
    - Encouraging nurses and midwives to expand their scopes of practice into digital health, informatics and research through scholarships and the creation of nurse analysts and researcher positions in the primary care setting. This investment would add to the quality improvement of programs.

Encourage interdisciplinary learning

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

83. A cultural system change is needed to ensure that ENs are more effectively utilised, including initiatives to educate healthcare staff and employers on the scope of practice of EN's. These educational initiatives can result in an application of knowledge by the multidisciplinary team and employers to allow ENs to practice to their professional potential.[44] Allowing ENs to work to their full capability based on their training will increase workforce productivity and advance their nursing roles.[45]

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

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

Remove the necessity for collaborative arrangements for NPs and Ems

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

Fund increased numbers of NP positions in primary healthcare, including home-based, community care and those working across services, i.e., outreach and in reach

86. For aged care, having more NPs would greatly reduce ED admissions, ambulance costs and hospitalisations. In rural and regional areas, NPs and APNs make access to health care more accessible and allow more services to be provided to Aboriginal and Torres Strait Islander populations.

Remove funding barriers for NPs

87. To work to their full scope of practice, NPs and EMs require access to the MBS and PBS, and incentives for bulk billing equivalent to medical practitioners who work in primary healthcare. The ANMF recommends revisiting and implementing the recommendations made to the MBS Taskforce by the Nurse Practitioner Reference Group (NPRG).[46] The NPRG presented 14 recommendations for funding services that NPs already provide. None of the recommendations or the three alternative recommendations were accepted, demonstrating a lack of understanding or knowledge about the role of NPs by those on the MBS task force. The decisions made by the MBS Taskforce not only rejected all recommendations of the NPRG but sought to impose additional restrictions on services provided by NPs.[47] None of the MBS Taskforce additional restrictions were evidence-based.

Additional views

The broadest range of views will give the review a thorough foundation on which to consider new policies and regulations.

11. Please share with the review any additional comments or suggestions in relation to the scope of practice.

88. The ANMF welcomes the Australian Government's scope of practice review. Nurses and midwives work in and value multidisciplinary teams (MDT) and must be respected as equal members with the skills, knowledge, and experience to work as safe and autonomous practitioners.

89. Nurses and midwives already lead care in primary health contexts, working with people to plan and meet health goals. Supporting nurses and midwives to work to and expand their scope of practice presents the opportunity to increase the number of primary healthcare practitioners providing equitable access to primary healthcare and better health outcomes for all people living in Australia. Through such actions, the possibility exists to reduce unplanned nursing and midwifery workforce attrition by improving career trajectories and job satisfaction for nurses and midwives.

90. Allowing nurses and midwives to work to their scope of practice will require support from governments and communities and involve legislative, fiscal and cultural change that removes the types of barriers discussed earlier whilst putting in place enablers such as, educational support and incentives, removal of the medical practitioner stranglehold on primary health and the deletion of collaborative arrangements for NPs and EMs. This will ensure people are seen by the right healthcare practitioner, at the right time and in the right place.

Conclusion

91. Thank you for the opportunity to provide feedback to the Australian Government's public consultation for the Independent Scope of Practice Review. The ANMF welcomes this review, firmly believing that nurses and midwives working to their scope of practice will improve access and delivery of safe and appropriate primary health care in Australia.

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