Submission by the Australian Nursing and Midwifery Federation

Submission to the Australian Government re Unleashing the potential of our health workforce – Scope of Practice review. Response to Issues Paper 1

March 8, 2024

Australian Nursing & 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 326,000 nurses, midwives and care-workers 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 each and 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 trade union and professional organisation provides 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 on the Scope of practice review: Issues Paper 1. The importance of accessible and affordable primary healthcare is well understood, offering the opportunity to reduce the demand for emergency and acute hospital services and result in a more effective and efficient health system that focuses on person centred care while reducing overall healthcare costs. Nurses and midwives working to their full scope of practice play an integral role in improving access to appropriate and affordable primary healthcare.

Overview

6. The Scope of Practice (SoP) Review presents an opportunity to review and revise the primary healthcare (PHC) system in Australia making it more responsive to need, accessible and affordable for people living in Australia. Addressing the importance of preventative and proactive approaches to health is also an essential element of PHC. Such measures will help prevent avoidable emergency centre presentations and associated resource burden on the acute sector. Investment in primary healthcare offers the opportunity to improve health outcomes for people living in Australia. There is enough work for all health professionals to work autonomously and as part of multidisciplinary teams if supported to do so. Allowing regulated health practitioners to work to their SoP and ensuring that funding streams support the provision and access to affordable health services must be first and foremost.

7. Definitions of PHC are often misunderstood and poorly defined. The definition of PHC must be a foundational element of the SoP review. Too often PHC is seen as existing only in general practices and controlled by general practitioners (GP). This is a myth that has been developed

in Australia over the past 12 or so years, to the detriment of the public, who find it increasingly difficult to access a GP and/or afford the associated out of pocket costs.

8. The World Health Organization (WHO) states that PHC…

   "… is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and 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," [1]WHO and UNICEF. Further, WHO suggests that PHC has three inter-related and synergistic components including,

   - Comprehensive integrated health services that embrace PHC and public health goods and functions as central pieces,
   - Multisectoral policies and actions to address the upstream wider determinants of health, and
   - Engaging and empowering individuals, families, and communities for increased social participation and enhanced self-care and self-reliance in health.[2]

9. PHC exists across communities and is not restricted to general practice, nor is it is the exclusive domain of general practitioners or general practices, as is commonly assumed and reinforced through funding models, the media, and governments. The range and variety of PHC initiatives were illustrated in the ANMF's initial submission to the SoP review, providing an overview of, though not exhaustive, nurse and midwife led services that deliver appropriate and affordable PHC based on access and equity rather than the creation of profit. Nurse, nurse practitioner or midwife led services provide essential case management, coordination, and delivery of care. The assumption that PHC involves general practice only, delivered by GPs only, has resulted in GPs claiming a gatekeeper role in PHC services, effectively locking nurses and midwives, and other health professionals out of funding streams for coordination and delivery of PHC services.

Legislation and regulation: Consultation questions

10. **What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice?**

11. Clear legislative protections and government commitment are required to ensure that nurses and midwives are given the appropriate clinical governance to perform to their full scope of practice (SoP). 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 offer a safe and affordable choice of primary health practitioner.

12. Removing jurisdictional and organisational barriers that limit the scope of practice of nurses and midwives is an essential key to PHC reform. As the Issues Paper identifies, 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[3] and should be addressed.

13. In several instances, organisational policies restrict nurses and midwives in their practice. A national workforce standard/policy enabling nurses and midwives to work to their scope of practice by overriding organisational particularities is needed. This would allow practitioners to move to other positions, organisations or across jurisdictions, knowing they can work to their scope of practice wherever they are located. It would also reduce confusion for employers who are trying to understand multiple scopes of practice across disciplines. Harmonising the Drug and Poisons legislation nationally is one example that could improve nurse and midwives' ability to work to their scope of practice.

14. Current restrictions on Nursing and Midwifery Board of Australia (NMBA) endorsed nurse practitioners impede their ability to refer people for diagnostic testing or limits access to the Medical Benefits Scheme (MBS) and pharmaceutical Benefits Scheme (PBS) items. This must be overcome through legislative change that ensures NPs in all state and territories can access MBS and PBS, make referrals and order diagnostics to the same extent as general practitioners (GPs) and be remunerated at the same rate as GPs for the same work, without disadvantage to the consumer. This would allow people seeking healthcare to choose the most appropriate practitioner for them, improve their access to healthcare and prevent fragmentation of care.

15. Incentive payments must be redirected. Funding models and incentive payments tied to medical practices and general practitioners result in gatekeeping, fragmentation of care and should be changed. If used, incentive payments should be directly available to all health professionals working in the PHC setting. Ideally, these large amounts of funding would be redirected to block, blended or salaried models of funding that can also support nurse and midwife-led models of PHC care.

16. There is a need to move away from government subsidised profit driven healthcare. Healthcare must be seen as a human right, not a business driven by profit. Primary healthcare funding must move away from fee-for-service and outsourcing, toward block or blended funding 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 such as that seen in the federally funded National Aboriginal Community Controlled Health Organisation (NACCHO) or 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 practitioner for primary healthcare.

17. **To what extent do you think a risk-based approach is useful to regulate scope of practice (i.e., one which name core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles)?**

18. The ANMF supports streamlining the way nurses and midwives work across organisations and jurisdictions. The introduction of a national approach and the removal of restrictive jurisdictional and organisational policies and legislation impacting nurses and midwives' ability to work to their scope of practice would be welcomed as would the harmonisation in referral authority and review of the self-regulated and unregulated workforces. The ANMF would support regulating unregulated health workers such as assistants in nursing (however titled).

19. The Professional Practice Framework (PPF) for nurses and midwives embodies the identity of the professions and provides the core requirements to practice and this should not be lost. Mapping the PPF to other health discipline frameworks would reveal commonalities that could contribute to an overarching framework for health practitioners. Identifying elements of nursing and midwifery work which overlaps with other regulated professions and acknowledging this through legislation and regulation, could help to increase access to PHC and allow health practitioners to work to their SoP. The success of such an approach was demonstrated during the COVID19 pandemic in Australia when a range of disciplines could administer vaccinations.

20. Interdisciplinary learning (IDL) and encouraging an understanding by health practitioners about the scopes of practice and referral pathways of other members of the multidisciplinary team is an essential element in understanding, developing, and implementing multidisciplinary care.

21. Inter professional learning (IPL) 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 increase understanding and prevent imposition of jurisdictional and organisational policies that restrict the individual nurse or midwife's scope of practice.

22. While the ANMF supports streamlining pathways and facilitating health practitioners working to their scope of practice and identifying common areas of practice that improve access to PHC by those living in Australia, it does not support credentialing or micro credentialling for individual nurses and midwives. Credentialing overlays an additional level of regulation and monitoring, may add further expense to the cost of NMBA registration and potentially results in nursing and midwifery being viewed as a task driven occupation rather than a profession requiring advanced knowledge, critical thinking, and expert clinical judgement in decision-making processes.

23. Clinical Care Standards developed by the Australian Commission on Safety and Quality offer quality statements that describe the care people should be offered by health professionals and health services for a given condition or defined pathway. Similar approaches could be employed for overlapping areas of practice. These cover all disciplines involved in the care and offer an alternative to an agnostic model of credentialing.

24. **What do you see as the key barriers to consistent and equitable referral authorities between health professions?**

25. Current and disjointed State and Federal government approaches to healthcare funding, policy, and service provision have restricted nurses' and midwives SoP and added to the creation of fragmented care.

26. Current policy and funding structures for PHC, exclude non-medical health practitioners from providing accessible, equitable, affordable primary healthcare services, adding to the fragmentation of care. For example, nurses working in GP practices can only access MBS funding through connection to the GP, which restricts their SoP and their capacity to provide continuity of care and contributes to negative outcomes for their communities. Although now being addressed by the Albanese Government, the requirement for collaborative arrangements between NPs and GPs, and the inability of NPs to access the MBS regarding referrals for diagnostics or specialist care presented significant barriers.

27. The Australian public has a right to expect access to affordable and appropriate PHC from the right health practitioner at the right time and as close to their home as possible. The ANMF supports the ability of nurses and midwives to refer people to other health professionals and to order diagnostics. The key barriers to these practices include:

    a) The requirement for a person to visit a GP to access another health professional or service or access maximum funding under the MBS. This results in delayed care, fragmentation of care, added out of pocket expense, delayed diagnosis/treatment, and unnecessary, increased use of resources.

    b) Access to services. Those living in areas where access to a GP is limited or non-existent can result in the need for increased travel requirements or people delaying accessing healthcare which potentially results in later diagnosis, deterioration, and poorer health outcomes.

Employer practices and settings: Consultation questions

28. **What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)**

29. As discussed above, adopting a nationally consistent approach to healthcare, and removing jurisdictional and organisational policies and processes that restrict nurses, midwives, and other health professionals from working to their scope of practice would help to streamline the health system and reduce fragmentation of care. Employers need to be familiar with discipline specific scopes of practice and national legislation to ensure nurses and midwives can work efficiently and effectively to their scope of practice.

30. The proposed National Skills Passport (NSP) may offer a single place for workers to collate validated qualifications, subject outlines, work experience and job descriptions. It may also offer a system whereby nurses and midwives align their work with the standards for practice and other elements of the Professional Practice Framework. A system like the one found in Europe could help in developing a curriculum vitae and information sharing system, decided upon by the nurse or midwife, with potential employers and educational institutions. It is important however that this is not used as a credentialling tool. The way it is implemented would need to develop the trust of nurses and midwives regarding the safety of such a platform.

31. Industrial agreements to reduce organisational and jurisdictional pay disparities are important to ensure the same pay for the same work regardless of jurisdiction or health practitioner. This can be an issue for nurses and midwives living in border locations and for the lack of consistency in remuneration for nurses working in areas such as general practices. Government funding arrangements would also need to be considered for overlapping practices that can be carried out by a variety of regulated disciplines for example, vaccination administration.

32. Employer support in the form of funding and time to enable access to professional development and education helps nurses and midwives remain current in their practise so they can competently and safely work to their SoP.

33. To work to their scope of practice, all nurses and midwives require safe workplaces including ongoing support, safe staffing levels, mandated professional development opportunities and reflective supervision that is supported and enabled by employers.

34. **Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?**

35. Employer support for nurses and midwives to undertake post registration education and professional development would assist these disciplines to maintain and work to their scope of practice and meet their regulatory requirements. It would also allow nurses and midwives to expand their scope of practice and safely move into new and developing contexts of practice where required.

36. The proposal for the introduction of designated nurse prescribers is under review by the

NMBA. This practice would potentially improve continuity of care for recipients of health care and those living in aged care environments. This extension to a nurse's scope of practice will require new models of care and employer supported implementation and promotion.

37. Ensuring enrolled nurses (EN) can work to their scope of practice and are more effectively utilised as members of the multidisciplinary team requires employer and organisational support. ENs have often been prevented from working to their SoP and making their full contribution to health care delivery, because of organisational policies and lack of understanding about the role. Employers must support ENs to practice in accordance with their educational preparation, experience and assessed competence to work to their full scope of practice and achieve their professional potential.

38. **How can multidisciplinary care teams be better supported at the employer level, in terms of specific workplace policies, procedures, or practices?**

39. Access to digital systems, which allow connectivity across the healthcare system, has been inadequate for many years Ensuring interconnectivity across all sectors including PHC, aged care and the hospital sector would improve outcomes by improving communication between multidisciplinary teams across a person's journey through the health system. Transitions of care are a time when the safety of the person is at risk. Improving digital connectivity will assist in mitigating such risk by allowing MDTs to work together across contexts, resulting in improved continuity of care and safety.

40. Employers can work with MDTs to establish roles and responsibilities, ways of working and formalising these through position descriptions, policies, and guidelines.

Education and training: Consultation questions

41. **What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?**

42. Nurses and midwives expand their scope of practice by undertaking education offered through universities and the vocational education and training (VET) sector and based on their reflection and assessment of their learning needs regarding the work they do. Educational institutions are accredited to award qualifications and this together with a nurse's work history offers the best way for nurses and midwives to demonstrate increasing levels of knowledge and skill without the need for credentialling. However, many courses are prohibitively expensive. A postgraduate, single subject at university can cost over $2,500 which would mean a graduate certificate could cost upward of $10,000 and a Graduate Diploma would cost approximately $15,000 – $20, 000. While the higher education contribution scheme (HEC) is available to support some courses, the increasing yearly indexation on HECS debts makes it prohibitive for many. For example, in 2024 HECs indexation

was over 7%. In most cases such an increase does not align with the pay increases that might follow from completion of a post graduate qualification. This essentially stops many nurses and midwives from accessing postgraduate education and expanding their SoP. While removing the HECS fees for nurses and midwives undertaking postgraduate studies is ideal, the ANMF supports financial assistance and the extension of scholarships for nurses and midwives working in PHC to undertake postgraduate studies.

43. To assist with obtaining endorsement as an NP, the number of training places available needs to increase as does the number of ongoing, salaried NP positions to ensure those who receive endorsement as an NP can work to their scope of practice.

44. Release from duties for study, professional development and undertaking clinical practicum often presents a significant barrier. In most cases where clinical practicum is required for a postgraduate course, the nurse or midwife must take annual or unpaid leave which many nurses or midwives cannot afford. Any reform requires the removal of such barriers for example more accessible study leave. Often accessing study leave by nurses and midwives is arduous, rejected and disincentivised as a result of complex application processes.

45. **How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements, or advanced practice) be improved?**

46. The NMBA requires all nurses and midwives to demonstrate continuing professional development and ongoing learning for competence to practice and this is supported by the ANMF.

47. A National Skills Passport may offer an opportunity for nurses and midwives to collate and share validated qualifications from accredited providers for seeking recognition of prior learning especially if a passport included subject outlines for each of the subjects completed by the practitioner. However, endorsement on the National Register held by the NMBA and AHPRA, of a nurse or midwife having achieved a post graduate qualification, is a fair and transparent validation mechanism for the professions, the public, other health professionals and employers and should not be lost.

Funding Policy

PRIMARY HEALTH CARE FUNDING TYPES

Fee-for-service: payment for each episode of care.

Block funding: lump sum payment allocated to service provider.

Bundled funding: single payment for all services related to a specific treatment, condition or patient parameter, possibly spanning multiple providers in multiple settings.

Blended funding: combination of funding streams, such as block/bundled plus fee-for-service.

Capitation: payment based on the number of patients enrolled or registered with the practice.

Value-based care: Payments which link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics.

Program grants: lump sum payment allocated to a specific program.

Salaried workforce: health professionals earn a salary rather than being funded through one of the above funding models.

Delegated funding: a term which appeared through consultations, which refers to practices where a named health professional delegates activities related to care to another health professional but receives payment for that service.

48. **How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?**

49. Many PHC funding streams are tied to general practice and general practitioners and are based on a fee for service model. These approaches limit the work of non-medical PHC practitioners and restrict their scopes of practice. To allow nurses and midwives to work to their scope of practice in PHC, sustainable, untethered funding must be available and based on outcomes rather than activity.

50. Block funding to support salaried positions in nurse led clinics such as the ACT Walk in Centres and midwife led practices such as midwifery group practices should be available.

51. The requirement for the employment of at least one full-time or part-time general practitioner (GP) for the Work Incentive Payment (WIP) Practice Stream should be removed.

52. The funding for the employment of nurses and midwives under the WIP Practice Stream should be separated from other members of the primary healthcare multidisciplinary team.

53. Funding should be made available to develop a national policy on home birth, promote midwife-led models of care, and the removal of barriers (e.g., collaborative arrangement requirements, difficulties regarding access to indemnity insurance) to facilitate improved conditions and scope for privately practicing midwives.

54. Move away from activity-based funding and the outsourcing of primary healthcare funding models. Introduce block funding, blended and/or salaried models where health practitioners work autonomously but collaboratively for a wage in publicly funded and administered models of care. Redirect WIP incentive payments into these models.

55. Resource provision for planning and evaluation of midwife and nurse-led services, including providing resources to assist nurses in evaluating, planning, collecting, analysing, interpreting, and reporting on service data for funding applications and maintaining sustainable services.

56. Provide permanent funding for the 19(2) Exemptions Initiative to allow services provided by PHC providers in rural and remote areas to be claimed against the MBS and extend access in regional and metropolitan areas.

57. **Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary healthcare system?**

58. The system needs to move away from fee-for-service and outdated incentive models to publicly funded, salaried models of care that do not rely on multiple and complex income streams, applications, and reporting requirements. Existing systems create complex administrative burden and take clinicians away from the people seeking PHC and are driven by activity rather than provision of services according to needs assessment. Nurse and midwife led teams who work for a wage, such as those found in the Walk in Centres in the ACT are driven by the provision of person centred, comprehensive healthcare rather than profit creation. Additionally, a cost benefit analysis should be considered regarding money saved by PHC practitioners due to the prevention of unnecessary and avoidable hospital presentations/admissions.

59. **What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?**

60. Some disciplines will resist change especially if theirs is based on a private, profit driven model that attracts government subsidies and incentives. The risk of maintaining the status quo is that people living in Australia will continue to encounter increasing levels of difficulty accessing affordable and appropriate PHC services, increasing their risk of serious disease and placing increasing burden on the acute care sector. This is perpetuated by the current gatekeeper model of PHC which is too often underpinned by a profit motive.

Technology

61. **How do you think technology could be used better or differently in primary healthcare settings to enable health professionals to work to full scope?**

62. Technology is essential for communication in healthcare and has the potential to enhance continuity and improve safety during transitions of care. It has become an essential element of the way health practitioners provide and share care. Strong connectivity and appropriate use of technology has the potential to reduce care fragmentation and duplication of services by enhancing the communication between health practitioners and between the people for whom they provide care. For health practitioners to work to their scope of practice, they must be educated to use technology appropriately and effectively. Additionally, support must be readily available to assist practitioners trouble shoot, and problem solve. With the expansion of modalities such as telehealth, those accessing the health system must also have support to ensure access.

63. To allow health practitioners to work to their scope of practice, computer systems and platforms must be able to 'talk to each other' across the contexts of healthcare including aged care. This will allow connection of different areas of the health system.

64. Technology is an important part of diagnostics and can improve access to health services even where a specialist health practitioner is not present. With the increasing availability of AI in areas such as radiology, health practitioners, other than radiographers can provide services and access medical review remotely. This is especially important in areas where services are limited, or people are unable to travel.

65. Similarly, technology used to diagnose certain conditions are essential in the patient journey. To work to their scope of practice however, non-medical practitioners must be able to refer people for tests without the person incurring additional out of pocket costs or the need for them to visit a GP to obtain a referral. NPs for example should be able to refer people directly for an MBS supported diagnostic service without needing to refer them to a GP first.

66. Large geographical distances with small populations present a challenge for nurses and midwives working in these community settings. Nurses and midwives may feel unable to work to their scope of practice due to a lack of human resources. Nurse – led virtual clinics offer an alternative, using hybrid models of care that allow monitoring and evaluation through both virtual and face to face visits for those requiring ongoing PHC. This mode allows virtual consultation and case conferences with the MDT, including interpreters regardless of the location of the practitioner. Nurses and midwives can use this medium to work independently to their scope of practice and people seeking healthcare are able to choose where they would like to receive a consultation. To be successful governments must invest in strategies for digital inclusion for all community members, particularly those living in rural and remote locations, groups who are culturally and linguistically diverse, and First Nations people. A

national strategy will require implementation of fast, reliable internet access.

67. Technology also facilitates nurses and midwives working to and expanding their scopes of practice through access to online education and professional development. It also reduces costs, which as outlined earlier, present a significant barrier to accessing and completing post-registration education.

68. **If existing digital health infrastructure was to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?**

69. Improving the connectivity between all facets of a health service including primary, secondary, and tertiary levels, as well as aged care and pharmacy, is required to ensure an integrated system that encourages each member of the team to work to their scope of practice. Full connectivity would allow practitioners involved in the care of the person access to current and historical information that helps to tell the story of the person and their health and promote continuity of, and comprehensive care. One of the barriers is that different contexts employ different platforms depending on whether they are privately or publicly funded and limits the access to information.

70. Systems must be easy to use and education and ongoing technical support provided to ensure practitioners and those seeking PHC are confident and competent to use the technology effectively and efficiently.

71. With connectivity comes the ability to collect, collate and analyse data quickly, offering opportunities to identify disease trends or gaps in service provision and assist health practitioners understand how they might best maintain or extend their scope of practice to meet the needs of the community.

72. **What risks do you foresee in technology-based strategies to strengthen primary healthcare providers' ability to work to full scope, and how could these be mitigated?**

73. Practitioners who do not have access to the technology or refuse to use it will impact on the delivery of comprehensive care, particularly continuity and transitions of care.

74. Mistrust by the public who fear breaches of their data and confidentiality and refuse to participate in programs such as MyHealth Record will require assurances that data sharing systems are safe.

75. There is a risk that systems may be poorly designed and lack the security needed to keep data safe and confidential.

Concluding remarks

76. The ANMF values the opportunity to respond to Issues paper 1 scope of practice review. Nurses and midwives in Australia offer an extensive, educated, skilled and motivated workforce. When able to work to their scope of practice, within the contexts of multidisciplinary teams as equal but autonomous practitioners, they hold the key to affordable and accessible PHC care for all people living in Australia.

---

[1] World Health Organization (2018) A vision for primary healthcare in the 21st century: Towards universal healthcare and the sustainable development goals. Geneva.

[2] World Health Organization (2018) A vision for primary healthcare in the 21st century: Towards universal healthcare and the sustainable development goals. Geneva.

[3] Queensland Health (2022). Emergency Nursing. Improving access to care. Vision, solution, opportunity. Queensland.