RACGP Submission Nurse Practitioner Workforce Strategic Plan Consultation

February 2023

RACGP

Contents

RACGP submission to Department of Health and Aged Care re: Nurse Practitioner Workforce 10-year Strategic Plan

1.Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health and Aged Care (the Department) on the Nurse Practitioner Workforce 10-year Strategic Plan (the Plan) consultation draft.

The RACGP has developed this written response rather than responding via the online survey. **The RACGP's response to the Plan is from the perspective of nurse practitioners (NPs) working in primary care settings.**

The RACGP is Australia's largest professional general practice organisation, representing over 43,000 members working in or toward a specialty career in general practice including four out of five general practitioners (GPs) in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support GPs to address the primary healthcare needs of the Australian population.

2.RACGP overarching position and key recommendations for 'the Plan'

2.1. RACGP position

The RACGP recognises the value nurse practitioners can add when they work collaboratively as part of a general practice team delivering coordinated care and supports the role of nurse practitioners within general practice teams, either co-located or external to the general practice location.

The RACGP position on nurse practitioners (NPs):

- recognises the valuable role of NPs in primary care as part of a general practice team
- does not support proposals which expand the NP scope of practice to provide additional Medicare Benefits Schedule (MBS) funded services
- supports an appropriately funded collaborative and integrated model of healthcare between patients, their GP and other healthcare providers
- supports increased funding of the Workforce Incentive Program (WIP) Practice Stream to encourage more general practices to employ practice nurses and NPs as part of a general practice-based multidisciplinary care team
- does not support NPs working independently.

GPs have developed an extensive curriculum and Fellowship pathway that has led to specialist recognition by the Australian Health Practitioner Regulation Agency (Ahpra) and an ability to work independently across the broad scope of practice in primary care. Other health professionals wishing to practice autonomously, duplicating services within a GP's scope of practice, must be required to meet the same standard of training and assessment and ongoing Continuous Professional Development (CPD).

Continuity of care is at the heart of general practice and is patient centred. Patients who receive continuity of care have better healthcare outcomes, higher satisfaction rates, and the healthcare they receive is more cost-effective.[1] The

RACGP does not support models of care where multiple health professions offer the same service as GPs or where health professionals are offering fragmented primary health services independent of a patient's usual GP.

The RACGP recognises the desire to grow, expand and build upon the NP workforce and would support this within the general practice setting and other medically led team-based settings where there is less risk of fragmentation or duplication. Growth for the sake of growth is not a workforce solution. The health workforce must be responsive to community need and cost-effective. Responsible use of health resources is key to preventing duplication and wastage.

Healthcare in rural and remote locations is nuanced and favours flexible arrangements over rigid policy. Whilst NPs can play an important role in areas of need working in partnership with other healthcare providers, NPs working independently is not a long-term workforce solution as it creates a two-tiered system. All patients should have access to a GP who can coordinate their care, whilst also providing high quality, safe medical diagnosis and management for all presentations in the community context.

The RACGP is concerned that Australian policymakers continue to propose new workforce solutions based on overseas models of primary care that require expansion of independent scope of practice for other health professionals. These proposals are often profession-led and the volume and quality of evidence for patient health outcomes and cost-effective healthcare utilisation does not stack up compared to the large evidence base supporting the cost-effectiveness of GP-led care. Local and international evidence shows that better support for, and use of, general practice is associated with lower emergency department presentations and hospital use[2,3,4,5,6], decreased hospital re-admission rates[7], health benefits for Aboriginal and Torres Strait Islander communities[8,9] and significant savings for the healthcare system[10,11,12]. Despite NP modelling in other countries, there is no evidence that expanded scope of practice has assisted with medical practitioner workforce concerns or improved distribution to areas of need. There also does not appear to have been sufficient consideration given to the budgetary impact of independent practice by NPs.

Whilst expanding scope may assist with improving job satisfaction and retention, it should not be the driving motivation for change. These alternative models propose siloed care and do not capture the broad range of health professionals in primary care such as GPs, rural generalists, Aboriginal Health Practitioners and Workers, registered nurses and allied health professionals. This is further demonstrated by the timing of the consultation on the Nurse Practitioner Workforce 10-year Strategic Plan which seems out of step with the Strengthening Medicare Taskforce report looking at solutions to key primary care challenges.

If a truly collaborative care model is to be achieved, it would require the Nursing and Midwifery Board and Medical Board of Australia to jointly develop a training standard of high-level clinical practice benchmarks. Additionally, a governance group should be established to perform both a retrospective skill and qualification assessment as well as monitor and evaluate the ongoing integration of NPs in the wider healthcare community.

Australia has a world-class primary care system that we must protect. To this end, the RACGP has provided detailed recommendations feedback overleaf on the proposed Nurse Practitioner Workforce 10-year Strategic Plan.

2.2. Key recommendations for 'the Plan'

1. Support a model of NPs in primary care working as part of a general practice team.
2. Strengthen existing collaborative arrangements rather than remove them. All collaborative care models should incorporate the following principles:
    a. The nurse practitioner is employed, contracted by or otherwise retained by a GP or general practice, or
    b. The nurse practitioner is embedded in the general practice team and either sees patients on referral from the GP(s) directly, based on practice arrangements, and
    c. The nurse practitioner must have a written collaborative care agreement in place with the patient's usual GP.
    d. Should be limited to Medicare eligible services.
    e. The NP and GP should both service the same patient population to avoid fragmentation of care.
3. Increase funding for GPs to provide appropriate oversight and supervision of NPs as part of collaborative arrangements.
4. Consider diverting funding from Primary Health Networks (PHNs) to enable GPs to have NPs based in their practice.
5. Consider a clinical learning pathway with formalised assessment to improve recognition.
6. Provide clearer actions on how to integrate NPs into the workplace.
7. Increase WIP funding for NPs in general practice in addition to practice nurses and pharmacists and increase rural incentives.
8. Provide specific funding for cultural safety training so the whole team can provide a culturally safe environment for Aboriginal and Torres Strait Islander people.

3.Overarching comments

3.1. Aboriginal and Torres Strait Islander communities

The RACGP strongly supports the integration of cultural safety into the Plan and the meaningful involvement of Aboriginal and Torres Strait Islander people at every stage of care.

As part of this, cultural safety training should be embedded throughout the workplace and include an understanding of context and a tailoring of practice with face-to-face training, and regular follow-up and refreshment of training.[13,14] Targeted funding for cultural safety training may be necessary so that the whole team can be trained and the broader workplace environment is culturally safe.

The RACGP supports measures to encourage First Nations peoples into the health workforce.

4.RACGP comments on – '*Section 1: Nurse Practitioner: the case for action'*

4.1. 'National workforce planning outcomes'

The RACGP would like to address a section of the Plan which mentions the five system-level health workforce outcomes, the first of which is **'the right number of health professionals'**. Australia needs a robust health workforce to deliver high-quality, efficient and equitable healthcare.

The RACGP notes that since the first introduction of NPs almost 25 years ago:

- there are approximately 2200 registered NPs in Australia and of those, currently 522 are not employed as NPs[15]

- of the 1549 employed as NPs, approximately 13% are working in the primary care sector[15] and a large proportion of NPs (~30%) are working in rural, remote and very remote communities across various settings[16]
- NPs working in acute settings such as emergency departments and specialty outpatient clinics (eg respiratory, renal, cardiac, diabetes) operate at a high level of practice, but within a much narrower scope of practice than primary care. The average GP spends 12 years to become a GP in an area that has a wide and difficult scope. For this reason, we believe NPs working in a general practice team provides the best model in primary care.

4.2. 'Untapped potential: why Australia needs a strategic plan for the nurse practitioner'

According to the Plan, NPs aim to enhance the accessibility and delivery of person-centred care for all Australians through a well-distributed, culturally safe NP workforce. The Plan points to models in the United States and Ireland where NPs are embedded.

According to the 2016 cross-country analysis of the NP workforce[Error! Bookmark not defined.], Australia has a higher absolute number of NPs and rate per population (4.4) than Ireland (3.1). The Irish College of General Practitioners press release on 13 December 2022 raised concerns about their GP workforce crisis and asked for more investment in GP-led multidisciplinary teams. This is in alignment with Ireland's Health Service Executive 'Enhanced Community Care' initiative which promotes primary care multidisciplinary teams '**ideally based in a building where accommodation is appropriate and available to enhance multidisciplinary work**'.

The Commonwealth Fund's *Mirror, Mirror 2021: Reflecting Poorly – Health Care in the US Compared to Other High-Income Countries* report[17] **ranked Australia with Norway and the Netherlands as the top-performing countries overall**. **The United States ranked last on access to care**, administrative efficiency, equity and **healthcare outcomes. This is despite the NP workforce having been established for over 50 years with a large number of NPs in primary care.**

The proposal that more NPs working independently is a solution to a GP workforce issue seems flawed. Both Ireland and United States have embedded NPs into their health care systems, with the US also having a very large NP workforce. Regardless both countries are experiencing a GP workforce crisis reinforcing that role or task substitution is not an answer to a workforce issue.

4.3. 'Access to healthcare'

All patients should have access to general practice based primary healthcare that meets their health needs. Current challenges should not deter Australia from striving for equity of access. The RACGP continues to be alarmed by task substitution as a solution to workforce shortages and the prioritisation of rapid access to primary care through various health professionals without focusing enough on the core model of 'continuity of general practice-based care'.

In October 2022, the United Kingdom House of Commons Health and Social Care Committee *Future of General Practice* report[Error! Bookmark not defined.] showed there was a high level of consensus about the potential benefits of 'an array of professionals working in general practice' and identified that there needs to be better funding for these roles **in** general practice to allow GP supervision and flexibility in the type of staff recruited to meet local need. It also stated that 'there can sometimes be a trade-off between access and continuity, and…the balance has shifted too far towards access at the expense of continuity'. There is substantial evidence to show that continuity of care improves health outcomes.

General practice is highly accessible with national data showing only 1.2% of patients reporting they could not see a GP at all when they needed to, while one in two patients were able to see their GP within 24 hours for urgent medical care.[18] Improved technology and the introduction of telehealth, e-pathology and e-prescribing has further supported better patient access to more convenient and timely healthcare. This technology also enhances appropriate supervision and collaboration between medical practitioners and other health professionals.

Introducing independent NP access without connection to the patient's usual GP will fragment care, create siloes of care, cause duplication and waste limited health resources. The Australian Government has recognised general practice as the most appropriate setting in which to provide person-centred, continuous and coordinated care to the community.[19] The Strengthening Medicare Taskforce report reflects this.

A key role of general practice is to guide patients through the complexities of the healthcare system, and prevent unnecessary screening, testing and treatment. The increase in health system entry points, with multiple health professionals offering the same services, adds to health system complexity, duplication and fragmentation of care, and creates patient confusion around role delineation.[20]

4.4. 'Consumer experience'

The RACGP acknowledges the evidence provided about consumer satisfaction with NPs, noting that patients are similarly satisfied with GP care. More than 90% of patients report that their GP listens carefully, shows respect and spends enough time with them.[18]

General practice also offers the benefit of specialising in multimorbidity and the unique ability to provide continuity of care across a variety of health concerns with specialised input from a range of practitioners within the coordinated team, including NPs. This enables a 'one stop shop' approach for patients as the full range of health concerns can be diagnosed and treated. The ideal model emphasises patient safety in which each team member contributes their skills and services within the scope of their practice but can consult with a GP as needed.

It should be noted that NPs are being proposed in locations that would tend to be in Aboriginal and Torres Strait Islander communities, rural/remote communities, or low socioeconomic communities. These groups have more multimorbidity, more disability, including at a younger age, and a more complex mix of physical, psychological and social problems. Protocol driven care is likely to fall down in these groups. Whilst NPs could be helpful **as part of a team with a GP** in this context, when working independently it would be potentially harmful.

A more robust evaluation of the NP workforce is required, especially if not working in collaboration with GPs. Patient satisfaction should not be used as a measurement in isolation to roll out a less qualified workforce to the most vulnerable communities.

4.5. 'Cost-effectiveness'

Overall, the evidence supporting cost benefit of the NP role is inconclusive, as the benefits are hard to quantify.[21]

The RACGP is disappointed in how the consultation paper leads the public to consider that the KPMG study is robust evidence of cost-effectiveness. This is potentially misleading. There are other studies which do not show cost-effectiveness compared to usual care and that NPs may well be more expensive (due to duplication and greater use of resources), truncated in scope and rely on existing GP services for back-up.[22]

A US study[23] of NPs working in an emergency department showed that compared to physicians, NPs incur greater resource costs to treat patients yet achieve worse patient outcomes. The study also highlighted that NPs were more likely to prescribe drugs with potentially high errors of omission (i.e. antibiotics). In summary it suggests that NPs practising independently are not cost efficient.

The Strengthening Medicare Taskforce Report recommended team-based care supported by some form of Voluntary Patient Enrolment to drive improve cost-effectiveness with better outcomes for patients. In the Australian context, where patients can attend a number of practitioners, additional healthcare providers at differing levels of competency are likely to significantly worsen problems of duplication, and confusion particularly with medications and investigations. Cost outcomes relating to independent practice of nurse practitioners are likely to be worse given the potential fragmentation of care.

4.6. 'Alternative models of care'

International and Australian experience has repeatedly demonstrated that GP-led multidisciplinary healthcare teams achieve the best health outcomes for patients.[24,25,26] When situated at the centre of their patients' care, GPs provide continuity of care, reducing fragmentation and duplication of services. This can lower rates of hospitalisation and emergency department attendances, as well as lower mortality rates.[27]

Successful implementation of the NP role in aged care and other settings where it isn't possible for the NPs to be physically co-located with the GP in a general practice, depends on true collaboration.[28] A recent evaluation of GP and NP collaboration in the treatment of rural palliative patients demonstrates the benefits to patients through prompt initiation of treatment and good follow up.[29] This evidence supports the active participation of GPs in collaboration with NPs in delivering patient care.[30]

It is better to enhance existing models (NPs within teams with doctors and other health professionals) to provide patients with wraparound care. Siloed models are not cost-effective or sustainable.

The RACGP maintains that better support for the provision of general practice-based primary care can be achieved through implementing the *RACGP Vision for general practice and a sustainable healthcare system*.

This would include increased funding for general practices to employ, coordinate and lead a team of qualified health professionals, such as NPs, through the Workforce Incentive Program (WIP). The RACGP supports the WIP Practice Stream as it recognises the additional time required for GPs to effectively lead patient care across the multidisciplinary care team and encourages more general practices to employ NPs as part of a general practice-based multidisciplinary care team.

Our members have reported instances of NPs 'gaming the system' by using a GP in a distant health service to fulfill the requirements of the collaborative agreement. NPs working independently are not collaborating with their local GP and this should be avoided.

4.7. 'Improved labour force outcomes for registered nurses'

The RACGP does acknowledge that NP roles provide enhanced career opportunities and allow some registered nurses to maintain a clinical role in a more senior position with greater responsibility. This *may* have the potential to improve nurse retention and recruitment. Many GPs would welcome the opportunity to have a NP work in their general practice.

4.8. 'Related strategies'

The RACGP notes the reference to related concurrent national strategies, however the Strengthening Medicare Taskforce Report seems to be an obvious omission and the timing of consultations seems out of step. In particular, the independent practice of nurse practitioners is out of step with the recommendation for greater general practice team-based care supported by some form of Voluntary Patient Enrolment.

4.9. 'How the plan was developed'

The RACGP is concerned that investment in healthcare is being based on rudimentary research and consultation. The survey design is qualitative and not a good approach to workforce. The RACGP reviewed the Steering Committee membership and noted that GPs represented less than one-third of the group. Whilst the RACGP did have a representative on the committee, there seems to be an imbalance between specialist GP involvement and nursing representation which may result in recommendations that do not reflect a broad range of perspectives across the health system.

5.RACGP comments on Section 2: 'Outcomes and actions'

5.1. 'Theme 1: Education and lifelong learning'

The RACGP does not believe the actions in the plan support the NP workforce to enhance their skills and capability to address all population health needs. The entry requirements and education and training programs for NPs are not equivalent to those for GPs. To become a GP, you must undertake training in medicine, post-graduate hospital training and three years of supervised general practice training. Prospective GPs must pass examinations of an accredited general practice training program before being able to use the specialist general practitioner title.[31] There is consistency

across GP competency at the time that they achieve Fellowship. This does not seem to be addressed in the current NP education pathway.

The differences between a GP and NP that arise from different training pathways include:

- the breadth and depth of knowledge required for safe differential diagnosis in primary care
- depth of knowledge required to manage polypharmacy
- breadth of knowledge to work off-protocol when circumstances require.

The RACGP's opinion is that one of the barriers to formal recognition (by other professions) and improving the standards of NPs is the qualification pathway, which whilst requiring a Masters degree, does not appear to include formal clinical assessment requirements. A clinical learning pathway for NPs may further bridge the gap in this area.

The RACGP also notes the following inconsistencies between NP and GP education and lifelong learning requirements:

- NPs are required to complete a total of 30 hours of CPD annually (including 10 hours relating to prescribing and administration of medicines, diagnostic investigations, consultation and referral). This is **significantly less than the 50 hours** of CPD required of medical practitioners.

The RACGP supports plans for cultural safety training. It is also crucial that NPs working with Aboriginal and Torres Strait Islander people have standards of cultural safety equivalent to other GP/primary care services. This training would occur at both an individual and practice level.

The RACGP notes there does not appear to be a properly defined scope for NPs. The Australian College of Nurse Practitioners' *Clinical Collaboration, Scope of Practice and Collaborative Arrangements* fact sheet states that:

> *Nurse practitioners are fully responsible for working within their own scope of practice. Like other registered health professionals, the nurse practitioner will have a generalist scope of practice, and may have additional specialty practice built upon that foundation.*

The role of GPs and NPs are not interchangeable and therefore NPs are best utilised in a general practice team where GPs are available to perform the tasks unable to be provided by the NPs.

5.2. 'Theme 2: Recruitment and retention'

Recruitment and retention of NPs in general practice is hampered by a lack of funding to support them working within the general practice team. NP funding arrangements should not be separated from other GP practice team funding models. These funding models should facilitate access to NPs within urban, regional, rural and remote general practices, Aboriginal Community Controlled Health Organisations (ACCHOs) and other state-based clinics. The funding should:

- supply and fund GP decision support within each system
- remunerate NPs and GPs appropriately.

A general practice team provides a supportive team-based environment which could improve recruitment and retention.

The evidence presented in the consultation paper cites the 'SURGE' upskilling program which was implemented during the COVID-19 pandemic and functioned to upskill numerous nurses in critical care. To use this as evidence for appetite to upskill in primary care, aged care or disability, in the RACGP's view, is an extrapolation.

5.3. 'Theme 3: Models of care'

The actions related models of care will make the NP workforce more robust, but do not address how to build strong primary care teams that incorporate allied health and NPs to meet community needs. Clear strategies are needed on

how to integrate NPs in general practices and usual GP care, particularly if working to their full scope of practice. The listed actions are neither clear nor detailed enough.

There must be well-defined longitudinal relationships between health professionals to allow for effective clinical handover and a unified clinical record. This ensures GPs are up to date with patient care and can follow up accordingly, with opportunities for feedback and further engagement. The RACGP would like to see defined ways for GPs to provide feedback to the NP regarding adverse outcomes and ongoing care.

In regard to prescribing, NPs do not have the same training as doctors and whilst they have access to the full Pharmaceutical Benefits Scheme (PBS), any changes in this area need to be carefully considered to ensure patient safety.

5.4. 'Theme 4: Health workforce planning'

The RACGP acknowledges the need to address medical workforce maldistribution issues, particularly those that affect patients located in rural, remote or Aboriginal and Torres Strait Islander communities. The health workforce crisis in Central Australia and much of remote Northern Territory has been clearly articulated by Dr Sam Heard who argued that he does not see effective comprehensive healthcare or care coordination occurring without GPs and well-trained nurses, noting that locum nurses without primary care qualifications being offered incomes over $500,000 per annum was not the solution. National Aboriginal Community Controlled Health Organisation have also raised concerns about 'industry groups (that) continue to push for expanded scope of practice, without the integration within a primary health care team' in reference to the pharmacy sector.

The RACGP continues to advocate for and support initiatives which strengthen rural general practice and increase the number of doctors working in rural and remote Australia and other areas of workforce shortage. Increasing the NP workforce will not solve the maldistribution or healthcare access problem quickly, however, if NPs work within a general practice setting this would maximise the potential of a small workforce.

All patients should have access to general practice team-based (or similar primary healthcare team) models of care that meet their health needs. While allowing NPs to practice autonomously may increase patient access in some areas, the role of GPs and NPs are not interchangeable, and access to specific services offered by NPs will not meet the needs of patients requiring GP-led coordination across a range of providers.

There is also a risk that the relatively limited NP workforce will face the same maldistribution that has occurred in other health professions, causing further challenges with patient access.

Concerns have also been raised that NPs working independently in the more stressful environments of rural and regional Australia without proper support from a qualified medical practitioner are at risk of feeling unsafe and burning out and leaving the workforce.

6.RACGP comments on - Section 3: 'Measuring success'

The legislated requirement for collaborative arrangements ensures that NPs practising privately do not work in isolation from the medical profession. These arrangements have been recognised as important to ensure patient safety[32] and that health resources are used effectively,[33] but could be strengthened through the development of mechanisms to appropriately monitor and regulate the agreements. Working within this framework would provide clinical oversight, while supporting the delegation of specific services in which the NP is skilled. This will help ensure compliance with best practice, prevent the occurrence of adverse events and maintain continuity of patient care.

General practices are accredited and also already have many mechanisms established to monitor quality and collect data. This would also reduce duplicate expenditure and support robust evaluation of any reforms.

This section is unclear about the actual measures of success. To address the limited evidence regarding the role of NPs, the Plan should also set out the measures of success and approach to evaluation across the 10 years. This could include patient outcome measures, treatment outcomes and cost-effectiveness, as well as any other relevant measures.

7.RACGP comment on – 'Appendix 2: Nurse practitioner regulation and standards for practice in Australia'

Maintaining quality standards is paramount to patient safety and improving health outcomes across the population. The RACGP is supportive of NPs working in accredited general practice clinics being subject to the standards and expectations of general practice. NPs working outside the general practice environment need to be accredited to the same level of standards as general practice, and have the same level of scrutiny applied to quality and safety.

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