AGPN feedback to the Senate Standing Committee on Community Affairs re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

December 2009

Background to AGPN and this submission

The Australian General Practice Network (AGPN) welcomes the opportunity to provide this submission to the Senate Standing Committee on Community Affairs' (SSCCA) Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills.

AGPN is the peak national body of the general practice Network, comprising 110 local general practice networks (formerly known as divisions of general practice) across Australia, as well as eight state based organisations (SBOs). Approximately 90 percent of GPs and an increasing number of practice nurses and allied health professionals are members of their local GPN. The Network plays a pivotal role in the delivery and organisation of primary care through general practice and broader primary care teams. Major Network activities include:

- health promotion
- early intervention and prevention strategies
- chronic disease management
- medical education and
- workforce support

A unique feature of the Network is its linkage with a variety of health, community and other agencies at all levels – local / regional, state and national. This linkage means the Network has significant reach across Australia and is well equipped to deliver primary health care solutions tailored to locally identified needs. Delivering such solutions through general practice, the Network aims to ensure all Australians can access a high quality health system. In many cases, due to the changing demographics and burden of illness in Australia (an ageing population and increased levels of chronic disease) coupled with health workforce shortages, such solutions require more multidisciplinary team care and expanded/changing workforce roles.

To enhance the delivery of multidisciplinary team care in general practice, AGPN not only supports strong general practice medical workforce and education activities, it is also involved in several initiatives around nursing in general practice. One of AGPN's major national programs is the Nursing in General Practice (NiGP) program which has seen increases in the number of general practice based nurses from 2349 in 2003 to nearly 8000 (7824) in 2007[1]. AGPN has also been a lead research partner with the Australian National University (ANU) in a landmark study of nursing in general practice[2]. AGPN also work closely with the nursing profession through the National Primary Health Care Partnership (NPHCP)[3] as well as through a variety of other committees.

The focus of much of AGPN's work has been on practice nurses – registered or enrolled nurses who are employed by, or whose services are otherwise retained by, a general practice[4] - rather than on nurse practitioners – who generally hold postgraduate qualifications, work in more

[1] AGPN National Practice Nurse Workforce Survey Reports 2003 and 2007 http://generalpracticenursing.com.au/document-library2
[2] Phillips C, Pearce C, Dwan K, Hall S, Porritt J, Yates R, Kljakovic M, Sibbald B, 2008. Charting new roles for Australian General Practice Nurses. Abridged report of the Australian General Practice Nursing study: http://www.anu.edu.au/aphcri/Spokes_Research_Program/Stream_Three/Phillips_abridged_25.pdf
[3] For further information on the NPHCP see the NPHCP website at: http://www.nphcp.com.au/site/index.cfm.
[4] DoHA 2009 practice nurse definition: http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-nigp. See also: http://www.anf.org.au/pdf/Fact_Sheet_Snap_Shot_Practice_Nurses.pdf

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specialised roles and undertake limited diagnostic and prescribing activities. However, AGPN sees a role for NPs in general practice and as part of multi-disciplinary primary health care teams. AGPN's views on NPs are available in AGPN's PHC PS and in AGPN's Position Statement on Nurse Practitioners at: http://www.agpn.com.au/__data/assets/pdf_file/0020/16274/20090402_pos_AGPN-PHC-Position-Statement-2009-FINAL---Graphic-Designed.pdf and at: http://generalpracticenursing.com.au/__data/assets/pdf_file/0017/15371/Nurse-practitioner-in-General-Practice---Position-Statement.pdf. AGPN is also involved in the Nurse Practitioner Advisory Group (NPAG) convened by the Department of Health and Ageing (DoHA) and has additionally provided feedback on the amendments to the Midwives and Nurse Practitioners (MNP) Bill 2009 through this avenue.

AGPN's response to the Senate Select Committee's Terms of Reference

AGPN's response to the SSCCA's terms of reference (TOR) is provided below. In keeping with AGPN's role and scope of work as general practice networks, as outlined above, the response focuses predominantly on the first TOR (1a) and particularly on Nurse Practitioners (NPs). This TOR relates to the introduction of collaborative arrangements for nurses and midwives proposed as amendments to the Midwives and Nurse Practitioners (MNP) Bill 2009. Other TOR will only be addressed where they impact on these amendments and proposed collaborative arrangements.

Senate Select Committee's Terms of Reference

(1) That the following bills:

a. Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009

b. Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009

c. Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009,

be again referred to the Community Affairs Legislation Committee, together with the Government amendments to the bills circulated on 28 October 2009, for inquiry and report by 1 February 2010.

(2) In undertaking this inquiry, the committee shall consider:

(a) whether the consequences of the Government's amendments for professional regulation of midwifery will give doctors medical veto over midwives' ability to renew their licence to practice;

(b) whether the Government's amendments' influence on the health care market will be anti-competitive;

(c) whether the Government's amendments will create difficulties in delivering intended access and choice for Australian women;

(d) why the Government's amendments require 'collaborative arrangements' that do not specifically include maternity service providers including hospitals;

(e) whether the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers; and

(f) any other related matter.

General comments

The Australian General Practice Network (AGPN) is supportive of the amendments to the MNP Bill 2009 again being referred to the Community Affairs Legislation Committee. AGPN has already outlined its view on NPs in general practice in its 2009 Primary Health Care Position Statement[5] as

[5] AGPN Primary Health care Positions statement 2009 Care that puts people first: http://www.agpn.com.au/__data/assets/pdf_file/0020/16274/20090402_pos_AGPN-PHC-Position-Statement-2009-FINAL---Graphic-Designed.pdf

well as in its stand alone position statement on nurse practitioners[6]. AGPN's view on nurse practitioners, as stated in the AGPN Primary Health Care Position Statement 2009 is that:

Nurse practitioners will work collaboratively with the GP and the general practice team, providing clinical assessment and therapeutic management of health and illness presentations within their scope of practice. The role and duties of nurse practitioners in the general practice setting will be clearly defined, and teams will determine models to meet local population primary health care needs. Funding models will support the engagement and remuneration for nurse practitioners where community need is identified. (Page 23)

The size and configuration of general practices and clinics will be varied. General practice will remain predominantly privately owned and encompass large multidisciplinary clinics, large GP-centric practices, nurse-led clinics [within general practice], medium sized general practices, small and solo practices. Multidisciplinary care will be supported through eHealth solutions, infrastructure funding, funding / incentives for collaborative care, programs to improve the range of practice nursing and allied health professionals services to practices, local referral pathways, inter-professional learning, and education and training to embed team-based care. (Page 22)

AGPN endorses the introduction of collaborative arrangements and supports meaningful collaboration between NPs and others in the care team, especially general practitioners (GPs) for the following reasons:

- The GP record is likely to be the most complete set of data relating to a patient's health. Until systems which allow seamless sharing between providers, such as electronic health records, are universally in place, it is inefficient to create the data anew when appropriate collaboration will save the time as well as cost for this to occur. Collaboration also reduces risk in misinformation as it allows providers to have and share the same information about the patient.

- NPs, although broad based in their initial training, tend to specialise in a particular clinical field in their further training. As a result they have a more specialised and discrete scope of practice. This is not dissimilar to medical specialists. Collaboration with specialists is already encouraged from their GP via differential rebates for a referred visit compared to an un-referred visit. A similar situation should be considered for NPs to promote useful sharing of information to assist patient care.

- The more specialised scope of practice of the NP also means that it will be appropriate on many occasions for the patient to be reviewed in the wider medical context of general practice for their ongoing care needs. Without collaboration with GPs there is a risk that patient care could become more fragmented and/or that routine tasks are overlooked in the belief another party is dealing with it.

AGPN notes that in the proposed amendments, collaboration is not defined. (Subsidiary legislation is required to determine this). AGPN recommends that as a minimum, determination of collaborative arrangements should consider the following:

- NPs are registered nurses, educated[7] and authorised to function autonomously and collaboratively in an advanced and extended clinical role. This should be taken into account in determining "meaningful collaboration" in a way that respects both the nurse's and the medical practitioner's expertise and ensures continuous, quality patient care whilst also providing system efficiencies.

[6] AGPN Nurse practitioner position statement: http://generalpracticenursing.com.au/__data/assets/pdf_file/0017/15371/Nurse-practitioner-in-General-Practice---Position-Statement.pdf

[7] Usually a masters degree or equivalent is required.

- The scope of practice of a NP is already determined by the context in which the NP is authorised to practice. Collaboration is also part of the core competencies for NPs and a requisite of their registration. While clear guidelines about collaboration for NPs are useful they should ideally build on, rather than supersede or overlook the provisions for collaboration that NPs are already required to undertake.

- Agreements about collaborative arrangements must be especially heedful of creating additional workload on all parties involved, especially in terms of overly burdensome paperwork requirements, that slow the system down and/or that create additional inconvenience for patients.

- There are likely to be three main options for NP care models. In brief these are:
  1. nurse practitioners working as part of the medical practice team
  2. patients referred to a nurse practitioner by a medical practitioner
  3. patients seeking care directly from a nurse practitioner

  Although collaborative care arrangements for all three situations could be informed by the points above, each situation poses different degrees of risk to quality care. Different mechanisms for Collaboration are therefore recommended in each instance.

- AGPN's preference overall is for model one where NPs work as part of the general practice team with collaboration undertaken as a matter of course as part of usual practice protocols. It is however likely that options two and three will continue. AGPN is supportive of GP referral for model two. For model three in particular, AGPN would prefer that a means of providing relevant clinical information such as history, medications and the like, be available, and that feedback about treatment and any required follow-up be sent back to the patient's usual GP.

- It is likely that NPs will continue to provide services in certain areas where regular access by/to GPs and the wider medical context is difficult - for example in rural/remote areas and in indigenous communities. While we should continue to work towards achieving GP coverage in these areas we also need to ensure that any legislation or regulation for NPs to work in these locations is not so restrictive that patients cannot access care. At the same time, in some of these situations, there is insufficient work to warrant a full time GP being located in the area. Royal Flying Doctor Service (RFDS) visits augmented with NP visits is a useful model as long as avenues for collaboration and access to the wider medical context for ongoing care is available.

Other issues for consideration:

Where and how NPs work: the business context

In developing appropriate collaborative arrangements for NPs, it is important that the three scenarios above as well as the business models in which NPs are likely to be working are considered. Some likely situations are provided below:

- Specialist area nurse practitioners are likely to be working closely with medical specialists and their scope of practice is also likely to be clearly recognised and well understood. In this situation, the usual lines of communication via letter are likely to suffice for collaboration. Ideally this would be achieved through secure electronic means. The Network already has a key role in encouraging and supported the wider uptake and use of such systems in general practice and with adequate resourcing could expand this support to NPs.

- Specialist chronic disease NPs are likely to work within the state system or in general practice and collaboration via referral or shared records will also work well.

- The main area of concern is the "generalist" nurse practitioner who may establish practice in isolation to other practitioners to perform health checks or acute triage and management. Currently locum services and hospital Emergency Departments come closest to this model.

This is an area where duplication in effort and incomplete understanding of history and medication already exist and create increased cost and poorer outcomes than would be ideal. In this situation, electronic summaries of attendance forwarded to the usual GP should be a minimum collaborative arrangement to allow appropriate follow-up.

The importance of eHealth in supporting collaboration between NPs and others

It is ideal for communication between different providers, including NPs, to be provided by secure electronic means for review by the patient's usual GP and subsequent filing in the patient record. Where such a system does not exits, a minimum collaborative requirement should include a duplicated patient record with a copy sent to the GP and also given to the patient to convey to their GP. This dual approach increases the likelihood of useful information being available when the patient is reviewed. Relying solely on patients to relay messages to others in their care team is risky given the poor levels of health literacy, and places burden on the patient who is required to repeat their history to another health provider.

NPs collaboration issues with different patient types

Consideration of collaborative arrangements also need to take into account the various patient scenarios that exist. There are three main situations:

- Patients have one GP or practice that they use exclusively
- Patients have a GP they consider their "usual" GP but also see other GPs as convenience dictates for minor concerns
- Patients have not ever established an ongoing relationship with a GP or other health professional either due to robust good health or difficulties with access

Collaborative arrangements for patients in the first two categories are more straightforward as patients will tend to nominate their GP or practice for ongoing collaboration. Patients in category three however should, where possible, be strongly encouraged to establish such a relationship. Ideally their interaction with a nurse practitioner should promote and enable this. This will be easier for patients who are able to access a regular GP or practice. In areas where there is insufficient population to support a regular and continuing GP presence, it is likely that the "usual GP" will be a visiting service such as the RFDS. Mechanisms for ensuring good collaborative arrangements between the NP and "fly-in" or outreach type medical services, such as the RFDS, will need to be established so that patients can be linked into pathways for ongoing medical oversight and intervention as required.

AGPN is aware that specifications for collaborative arrangements have been jointly proposed through NPAG by the AMA and the RACGP. AGPN has given in principle support for these ideas, especially the need for GPs to be kept informed of NP care for patients through suitable collaboration. AGPN does not fully endorse these proposed Collaborative arrangements in their current format but would likely do so with some minor amendments. AGPN can provide the committee with these suggestions on request.

Overall recommendations

- AGPN supports the amendments to the Midwives and Nurse Practitioner (MNP) Bill 2009 again being referred to the Community Affairs Legislation Committee.

- AGPN supports collaborative arrangements between NPs and Midwives and others in the care team, as proposed in the amendments to the bill.

- AGPN recommends that including GPs in collaborative arrangements should be strongly encouraged so that patients can establish and maintain a continuing relationship with a medical generalist and have ongoing access to the wider medical context of patient care.

- Where patients are unable to establish links with GPs due to access reasons, then collaboration with other medical services that can provide wider medical care should be encouraged.

- AGPN recommends that the development of collaborative arrangements (as yet unspecified in the proposed amendments to the MNP Bill 2009) take into account:
  - The scope of work already defined for the NP and their requirement (as part of registration) to work both autonomously and collaboratively
  - Acknowledgement and respect for their qualifications and training
  - The need to avoid adding unnecessary and burdensome red tape to care protocols
  - The different scenarios in which NPs may work. Collaborative arrangements for each of these will vary.
  - A preference for working as part of general practice teams where this is possible

- AGPN also recommends that support for electronic collaboration between NPs and others in the care team is encouraged and progressed through for example, the implementation of universal electronic patient health records.