Submission from
the Australian Nurse Practitioner Association to
the National Health and Hospitals Reform Commission
Summary
The expansion of nursing roles has been an important feature of health care in recent years, stimulating much debate in which the role of the nurse practitioner has been central. The pressures on health care provision have encouraged re orientation of health services to cost effectively meet consumer needs whilst also facilitating the patient’s journey within the health system. Nurse practitioners have responded to this challenge, in a well planned and rigorous manner. They have developed advanced skills and expanded their scopes of practice, providing safe, comprehensive, timely and efficient access to excellent nursing care for their patients and their communities.

Nurse practitioners are senior clinical staff within their chosen specialty. They require a Masters degree or equivalent to register with their state nursing boards. With many years of experience they offer expert clinical skills that focus on recognition of the health needs of the whole person within the context of their environment. These highly developed skills are put to use in a variety of rural and remote settings, as well as in the mainstream city hospitals and other health care settings. The nurse practitioner role supports existing patient care while increasing access to services for those people have not had access to care before.

Amongst other expert skills, nurse practitioners make referrals to specialist medical and other health care providers diagnose and commonly prescribe medications while working within their extended scope of practice. This allows them to provide holistic, quality and opportunistic care for their patients.

Worldwide literature provides clear evidence that nurse practitioners are able to offer quality care, in an autonomous collaborative fashion, that complements other healthcare providers, resulting in seamless healthcare provision for patients.

The ANPA commends this submission to the National Health and Hospitals Reform Commissioners and makes the following recommendations.

**Recommendation One- Access to the Medical Benefits Scheme and Pharmaceutical Benefits Scheme for nurse practitioners**

This requires examination of the disjoint between state and national legislation to alter them to enable nurse practitioners to access the Medical Benefits Scheme and Pharmaceutical Benefits Scheme. The principles of the universality of Medicare and the Pharmaceutical Benefits Scheme are not upheld for the Australian community with this limitation to nurse practitioner practice. Access to the MBS and PBS will also contribute to reducing the inefficiencies generated by cost-shifting.

**Recommendation Two- Further expansion and implementation of the nurse practitioner role**

Further expansion of the nurse practitioner role into areas of need in the community and the support of health services to use existing authorised nurse practitioners who are currently without positions is required. This will allow a better integration and
coordination of care across all aspects of the health sector, particularly between primary care and hospital services.

**Recommendation Three- National registration and education standards**

The continued progression of standardised national registration and education initiatives in collaboration with the key stakeholders of the nursing profession is required.

**Recommendation Four- Funded nurse practitioner research**

Support of nurse practitioner research initiatives including dedicated funding. This will assist in nurse practitioner workforce development and improvements in frontline patient care from prevention right through to chronic illness management.

**Recommendation Five- Funded nurse practitioner education**

Provision of national and other nurse practitioner education scholarship programs in line with strategic directions such as, but not limited to cardiovascular disease or aged care. This will help to provide a well qualified and sustainable health workforce into the future.

**Recommendation Six- Community awareness and education program**

A coordinated and funded educational and awareness program through the media and other channels promoting the work of nurse practitioners and the value of choosing it as a career.
Introduction

Australian Nurse Practitioner Association (ANPA) Mission:
The ANPA is the national peak organisation for nurse practitioners advancing nursing practice and access to health care.

Aims:
1. To provide leadership, representation and support to improve the provision of health care to the general community.
2. To monitor and make recommendations regarding the ongoing developments of the role of nurse practitioner policy and positions.
3. To increase the level of awareness in the health care arena and to the general public of the nurse practitioner role.
4. To provide forums for discussion and dissemination of information.
5. To provide consultancy to improve the provision of health care to the general community.
6. To support relevant nursing research.

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice. (ANMC, 2006)

The Productivity Commission’s enquiry into Australia’s Health Workforce (2006), reports that nurses, as professional practitioners are under-utilised in terms of their capacity. It was suggested that this was due to entrenched hierarchies and traditional roles. The introduction of nurse practitioners in Australia has been remarkably slow compared to other developed countries where nurses are working in advanced roles autonomously and as leaders of large interdisciplinary teams with effective and efficient outcomes. The preparation of nurse practitioners for the workforce has been directly shaped by patient and community need and nurse interest. Nurse practitioners have extensive skills, experience and passion for their areas of expertise.

There are almost 300 authorised nurse practitioners in Australia with clinical expertise across multiple specialties including primary health, aged care and emergency. Unfortunately, less than 50% of those authorised are actually employed in nurse practitioner positions due to difficulties in implementing the position. The main impediment to the implementation of nurse practitioners relates to a lack of awareness and understanding by decision-makers and other health disciplines about the role. This relates to the notion that nurse practitioners work ‘independently’ when in fact the cornerstone of nurse practitioner practice is autonomy within a multidisciplinary
team. Nurse practitioners work in collaboration with medical colleagues, not for medical officers. Nurse practitioners work for their patients and communities. Nurse practitioners are not dependent on medical staff to indemnify their practice (Carryer & Boyd, 2003). Unfortunately this is not always evident. The following example is given. Many rural centres have infrequent medical specialist attendance. The nurse practitioner autonomously orders all diagnostic testing and medications and makes referrals with a view to maximising the patient journey through the health care system. Anecdotal evidence has demonstrated that there are visiting doctors being paid large amounts of money to attend rural areas who are having to duplicate and ‘sign off’ on the work (really just signing pathology forms and countersigning medication orders) of the nurse practitioner purely because the nurse practitioner is prevented from working to their full scope by having no access to the Medical Benefits Scheme including no provider number. It is no wonder that doctors are of the perception that they are responsible for the work of nurses when this role falls to them by default.

Disease profiles have moved to chronic and complex illnesses which require different approaches, management and treatments to those of the past. We need proactive, responsive models of care and innovative roles which are appropriate to the changing climate and demands of a modern health system.

Changing population needs and service availability have identified that not every patient needs a medical specialist to manage their care. Advanced practice nurses such as nurse practitioners who have extended training and education and are authorised to work in an advanced role are highly skilled in triage, managing and mentoring teams, counselling and educating patients and populations. Nurse practitioners work within a clear scope of practice requiring collaborative relationships with medical colleagues as well as allied health staff. They can manage patient’s care autonomously and make appropriate referrals for patients requiring expertise from medical colleagues and other health practitioners.

We believe that nurse practitioners are a solution to health workforce reform and optimum patient outcomes. The remainder of this document is divided into nine sections. The first two provide the evidence surrounding educational preparation and authorisation. The third section discusses the collaborative nature of nurse practitioner roles. Parts five to eight thoroughly explain the work of nurse practitioners including scope of practice, patient outcomes and legislated privileges. The final section demonstrates the flexibility and applicability of the role.

1. **Nurse practitioners are educated at Masters level**

The Evidence

- Nurse practitioners are highly experienced and educated nurses with a long term commitment to their local communities, area of specialty and the units within which they work. They provide a well qualified and sustainable health workforce for the future.
Masters of Nurse Practitioner courses for nurse practitioners are well established in NSW, Victoria, Western Australia and more recently Queensland. They are accessible by distance education for those in country Australia or those in metropolitan areas requiring flexible learning opportunities.

Examples of course content include but are not limited to, investigative methods for clinical practice, pharmacotherapeutics for advanced nursing practice biophysical processes and health assessment leadership and management. (The University of Newcastle, 2008)

Opportunities

1. There is a pool of approximately one hundred nurse practitioners currently prepared at Masters Level but who are not in nurse practitioner roles. One reason for this is reported as being due to the difficulty in implementing the role at a local level. Some of these authorised nurse practitioners, whom are not employed in a position that allows them to use their extended skills, are ready to be mobilised into the role for fast clinical care solutions.

2. Obstacles include lack of knowledge on how to create a nurse practitioner position, arduous pathways requiring time-consuming paperwork to put in business cases to employ one and people who are in decision-making positions that may have their own interests to protect. An example of an interest group with small relative member numbers but an active media department and a strong public voice is the Australian Medical Association (AMA). Unfortunately despite the plethora of outcome based studies the AMA is stuck on the concept that nurse practitioners are ‘independent’ when they are by definition autonomous and collaborative. (AMA, 2005). No general practitioner or other medical officer is excluded in the nurse practitioner model of care. In fact, evidence shows that these collegial relationships are enhanced and are to the benefit of patient outcomes. Unfortunately resistance from medical interest groups may be an attempt to protect doctor’s income rather than a genuine concern about patient wellbeing.

3. There have been no allocated funds specifically to support employment of nurse practitioners in any jurisdictions. Targeted funding is imperative for identification of areas of patient need, education of nurse practitioners and the implementation of the role. Commonwealth, State and professional organisation scholarship opportunities for university costs would be advantageous.

4. Commitment from local workplaces for funding, multidisciplinary team support, release from work to study and a guaranteed position at the completion of the Masters program would be advantageous. Direction from Commonwealth in this process would provide a framework for local implementation.
2. Authorised under state and territory legislation

The Evidence

- The introduction of nurse practitioners in Australia has been a considered process and planning their introduction involved many different groups, including consumers, nurses, doctors and educators. State and Territory governments have introduced the role carefully, with pilots and trials, to ensure that the service nurse practitioners provide meets the community expectations, and are safe and effective. (ACT Government, 2002)

- In Australia, ‘nurse practitioner’ is a protected title. This means that a registered nurse needs to be authorised by the registration body in their state/territory. Only those nurses who have achieved the required level of education and experience can be registered and practice as a nurse practitioner.

Opportunities

1. National registration initiatives will facilitate cross border issues, assist in the portability of workforce, benchmark education requirements.

2. Access to the Medical Benefits Scheme is imperative, so the disjoint between state and national legislation needs urgent attention. Nurse practitioners provide services in many community settings, including remote areas, aged care, and for marginalised or disadvantaged groups. They are authorised under state and territory legislation to practice in these areas. However, nurse practitioners cannot access the Medical Benefits Scheme or the Pharmaceutical Benefits Scheme. This means that if a nurse practitioner writes someone a script to be filled at a community pharmacy, the client would have to pay the full price. Also without access to the Medical Benefits Scheme, clients who use a nurse practitioner’s service in the community would have to pay and not be rebated. This has led to nurse practitioners being employed only in public systems where they can work around these restrictions, albeit with some limitations. In turn the flexibility of the role is impeded.

3. Work autonomously and collaboratively in a clinical role with a multidisciplinary team

The Evidence

- Nurse practitioners have higher degrees of autonomy than traditionally associated with nurses. This gives them the authority to determine practice and be more accountable for patient care using high level clinical decision making skills that are supported by academic preparation.
Medical organisations such as the Australian Medical Association acknowledge the contribution of nurses as ‘an essential part of the primary care team adding value and enabling the primary health care providers to deliver more services to patients. In the primary care setting the role of nurses is complementary to that of the general practitioners.’ (AMA, 2005)

Nurse practitioners are not dependent on medical staff to indemnify their practice (Carryer & Boyd, 2003). They are covered by vicarious liability within the public health system in the same manner as other nurses. Insurance outside the public sector could be available to them through organisations such as Guild Insurance who are currently recommended by the Royal College of Nursing Australia. (Guild Group, 2008) The AMA has said that ‘The AMA does not accept that medical practitioners should be legally responsible when errors of omission or commission by medically unsupervised independent nurse practitioners warrant subsequent medical intervention. Medical practitioners are not responsible for professional acts over which they have no control.’ (AMA, 2005) The ANPA supports them in this statement.

Nurse practitioners are a complementary service, which increases patient choice, adds diversity to patient care that enhances collaboration with the medical profession and other health care professionals and enhances the scope of the skill mix across the health care team. In rural and remote areas the nurse practitioner is part of a bigger team that is strengthening local care in an isolated community. An example of this is a youth health nurse practitioner in Gosford. The role works in a highly collaborative model that includes the Central Coast Youth Health Service teams, local GPs, nursing/medical specialists, Children and Young People’s Mental Health Service, Holden Street Sexual Health Service, Child and Family Health, Biala Sexual Assault Service, Gynaecology and Women’s Health services, Respiratory and Asthma Education Services, Drug and Alcohol Service, DoCS, Central Coast youth-related agency services and workers.

In regard to collaboration and aged care, “collaboration between general practitioners and nurse practitioners over the care of people living in residential aged care facilities has the potential to promote continuity of care, decrease hospitalisations and readmissions, enhance patient satisfaction, reduce costs, enhance working relations between medicine and nursing, and improve residents' access to care.” (Truscott, 2007)

**Opportunities**

1. There are currently limitations to the nurse practitioners autonomy, namely the issue of prescribing and subsequent access to PBS, ordering of diagnostic tests and referrals (these are discussed individually further in this document). Access and exit block in hospitals, delays to treatment, longer waiting times, additional patient suffering and additional cost are a result. Again, attention to
this is imperative.

2. Sustainable collaborative partnerships could be developed with all health care providers by acknowledging each others unique, valuable contribution. Part of this may be achieved by interdisciplinary learning and a strong, coordinated and funded educational and awareness program through the media and other channels highlighting the work of nurse practitioners is recommended (Wilson et al., 2005).

4. Nurse practitioners have been proven to deliver excellent patient outcomes

The Evidence

- The Australian nurse practitioner study Reforming Healthcare: Nurse Practitioners and workforce redesign is in its second phase. Phase two examines the practice and service profile of nurse practitioners and will give the first comprehensive overview of this component of the Australian workforce. More information can be obtained from Dr Glenn Gardner (ge.gardner@qut.edu.au) or Dr Sandy Middleton (sandy.middleton@acu.edu.au)

- A systematic review of the literature by Laurant (2008) demonstrated that patient health outcomes were similar for nurses and doctors. However in regard to patient satisfaction, it was higher with nurse-led care. Nurses provided longer consultations, more information and recalled patients more frequently compared to doctors. Laurant asserts that ‘in general, no appreciable differences were found between doctors and nurses in health outcomes for patients, process of care, resource utilisation or cost.’ (Laurant et al, 2008)

- In regard to emergency departments patients are shown to be satisfied with management of minor illnesses and injuries by nurse practitioners in the emergency department. (Wilson, 2008)

- Early reports indicate that the Diabetes Nurse Practitioner at The Children’s Hospital at Westmead makes a positive impact on avoiding hospital admissions, improves access to appropriate and timely care (Nurse Practitioner Outpatient Clinic, and DDCP), and frees up inpatient beds.

- In the ACT Nurse Practitioner Trial the anticipated patient outcomes of service were achieved in 91.9% of cases across four models. These were wound management, mental health, sexual health and military models. (ACT Government, 2002)

Opportunities
1. Nurse practitioners can be considered first as the providers of all types of care across a wide spectrum of patient needs from prevention to end of life care in primary health and tertiary sectors.

2. The implementation of standard outcome measures to evaluate nurse practitioner service and to benchmark against other nurse practitioners is imperative when nurse practitioners are to be implemented as a long term solution to health care issues. Tools are under development in order to achieve this. (Middleton, 2007)

5. Assessment and management of clients

The Evidence

- Nurse practitioners can provide early identification and preventative interventions to patients who are at risk of acute exacerbation of their illness as many of these patients have chronic diseases which have require frequent and close monitoring. Nurse Practitioners are able to provide a greater focus on prevention to the health system. The following models of practice demonstrate this principle.

- In the Australian Capital Territory, Rapid Assessment of the Deteriorating Aged at Risk (RADAR) is being trialled as a new model of care, with referral into the service via the general practitioner. The team is made up of two nurse practitioners and a geriatrician. The target group is the aged person who is sub acutely unwell, with the team role being to assess and manage them before they require hospital admission. The team visits them at home, or residential aged care facility, or in a clinic at the hospital Monday to Friday. The nurse practitioners liaise closely with the client’s general practitioner during the time of the intervention so that continuity of care is maintained. To date the majority of referrals have remained out of hospital. If admission has been required, people have been able to be admitted into a private hospital if they have private cover, or into the geriatric evaluation beds in public hospitals. This service results in a more appropriate admission, less time in hospital with early intervention occurring in most cases before the patient becomes seriously unwell. This service can also be associated with the Community Acute Care Program which has the capacity to organise IV fluids and antibiotics. This model provides evidence of nurse practitioners better integrating acute services and aged care services, and improving the transition between hospital and aged care.

- The ICU Liaison Nurse Practitioner model provides a nurse practitioner led rapid response team to review the deteriorating patient on the ward. The team can assess the patient, order the diagnostic test required and adjust or prescribe medications. The team also has the ability to fast track these patients to the ICU. This model is looking more and more attractive especially with the huge demand placed on the ICU medical staff in providing the Medical Emergency Team (MET) service. This has been implemented at Western Health in Victoria and they have found approx 75 - 80% of the MET calls are managed
effectively by the ICU Liaison Team with reduced ICU medical input. (Green & Williams, 2006)

- Wand and White sum up the mental health nurse practitioner (MHNP) role in the Emergency Department as focused on assessing and intervening to assist people in mental distress. The skills and expertise associated with this role being compatible with the provision of short-term outpatient care. (Wand & White, 2007)

Opportunities

1. Fast track zones can reduce the overall length of a patient’s stay in the ED by as much as 30% and improve patient flow through the ED as well as patient and staff satisfaction. These units are run by nurse practitioners which enables the medical staff to manage the higher acuity patients. (Cooke, Wilson & Pearson, 2002)

2. Nurse practitioners can be integrated into residential aged care facilities to circumvent patient admissions to hospital. An example of this is the assessment and management of a patient in a RACF with a urinary tract infection in a timely manner before it escalates to a delirium or systemic infection requiring hospitalisation.

3. Nurse practitioners have a role in improving the provision of health services in rural areas, improve Indigenous health outcomes and preventative health care. They are able to manage screening programs and early identification and intervention programs. An example of this would be a women’s health model providing Pap smears for women in remote aboriginal populations.

4. Nurse practitioners are able to integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health. They are an important consideration in the implementation of health care for the Australian community.

6. Direct referral of patients to other health care professionals

The Evidence

- Nurse practitioners employed in the public system are able to refer to a specialist medical officer within the public health domain. This allows patients to have timely access to a specialist for their individual requirements. A common example of this is the referral of women with an abnormal Pap smear requiring colposcopy to the Gynaecology Outpatient Department of a hospital by the youth health, sexual health or women’s health nurse practitioners. Any patient who requests to see a private specialist of their choice are referred to another medical officer usually
their GP to be able to access the specialist without incurring large costs through lack of rebate.

**Opportunities**

1. While nurse practitioners are authorised under state and territory legislation to refer their clients to other health professionals, in practice this is not feasible because the client would not be able to seek a the Medical Benefits Scheme rebate for those services if they choose to see a specialist that does not work within the public health system. For example, a nurse practitioner who specialises in continence/urology should be able to refer the client to a specialist urologist of their choice for further expert management. However, at present the client is forced to pay for an additional layer of servicing due to having to make an appointment with a GP, solely to get a referral to enable a Medical Benefits Scheme rebate for the urologist’s services.

2. Similarly, a nurse practitioner working with clients with dementia should be able to refer them to a neurologist or specialist physician to collaboratively manage co morbidities in order to improve the client’s quality of life. The additional layer of servicing required by limitations in the referrals process is essentially unnecessary and it imposes inappropriate health care costs, both to the individual client and to the health system as a whole.

3. With access to the Medical Benefits Scheme for nurse practitioners patients would be able to be referred to a private specialist of their choice without incurring costs. As it stands, patients choosing this option are not reimbursed and have to pay full price for services. This is inequitable.

**7. Prescribing medications**

**The Evidence**

- Nurse practitioners are the third and newest discipline alongside medical officers and dentists to have legislated prescribing rights.

- This legislated right is supported by advanced education at Masters Level

- The ANPA is a member of the National Prescribing Service (NPS) and endorses the principles of the Quality Use of Medicines. (NPS, 2008)

- The *Quality Use of Medicines for Nurse Practitioners* program is a new initiative of the NPS being lead by Charles Darwin University's Graduate School for Health Practice, the Australian Nurse Practitioner Association and other key stakeholders to address the need for continuing education in Quality Use of Medicines [QUM] for nurse practitioners and nurse practitioner candidates. The new program will commence in June 2008 and provide nurse practitioners and nurse practitioner candidates with
flexible ongoing education to ensure standards of practice are maintained within the principles of QUM:

1. Selecting management options wisely
2. Choosing suitable medicines if a medicine is considered necessary
3. Using medicines safely and effectively.

- Nurse practitioners work within a defined scope of practice and from a specific formulary. This ensures that they are competent in the prescribing of a specific, discrete type of medicine.

**Opportunities**

1. Access to PBS for nurse practitioners would allow patient access to medication not kept on the ‘Imprest’ system in public hospitals and community health centres. This would allow patients to present a prescription to a community pharmacist without having to pay full price for medicines. Currently if a nurse practitioner writes someone a script to be filled at a community pharmacy, the client would have to pay the full price. A specific example of this limitation is the provision of antiviral therapy for the genital herpes virus (valaciclovir or famciclovir). A patient with a concession card (eg. Health Care Card) can access medication for suppressive therapy with a doctor’s script and pays either $5.00 (pensioner) or $31.30 (others) for a one month supply. If the same assessment, diagnosis, prescription and management plan was to be provided by the sexual health nurse practitioner the cost to the patient would be $155.75 for the month. Patients stay on this treatment for at least six months. This is unacceptable, particularly for the vulnerable and marginalised patients that the sexual health nurse practitioner sees. This patient may be a young man who has sex with other men who is at a higher risk of acquiring HIV if he were not to be able to afford to take suppressive therapy for genital herpes. Having to then access a medical officer (which currently happens every time this type of patient presents) results in a double cost due to an unnecessary additional consultation and a delay for the patient only to access medicine at a manageable price for the patient. Accessing a medical officer in an outreach setting (or indeed rural or remote settings) has issues on top of this.

2. Additionally, there is also the real possibility that the duplication in services may have a negative impact of the health of the patient as they may have to wait a long time to see the general practitioner for a prescription and this wait may worsen the patient’s condition. Delay to treatment has been documented in the ACT component of the Commonwealth Aged Care Nurse Practitioner Trial (citation in process).
8. Ordering diagnostic investigations medications

The Evidence

- Nurse practitioners have state and territory legislated rights to order diagnostic investigations. Nurse practitioners work within a defined scope of practice and from a specific list of diagnostic tests that are directly relevant to the types of patients they are seeing and their specialty.

- This legislated right is supported by advanced education at Masters Level. This ensures that they are competent in the ordering of an appropriate, specific, discrete array of diagnostic tests.

- An example of this is the aged care nurse practitioner who may draw blood to be tested for Vitamin B₁₂, blood sugar level and liver function testing in the assessment of dementia in an older person. (ACT Government, 2006)

Opportunities

1. Access to the Medical Benefits Scheme rebate is essential for clients who have diagnostic tests, but with no Provider Number, tests ordered by a nurse practitioner are charged to the client at the full price. An example of this is that without access to bulk-billing or through a public health setting a person who required screening for HIV, hepatitis, syphilis, Chlamydia, gonorrhoea and a Pap smear would be out of pocket approximately $120. Nurse practitioners who order diagnostic tests for clients in the community are required to engage a GP in the process in order to ensure the diagnostic test costs attract a rebate. Delays in diagnosis and treatment occur when the client is waiting for a GP to see them to authorise the testing, especially in locations where GP services are limited.

2. The Medical Benefits Scheme access will increase the ability of the hospital to be reimbursed when diagnostic tests are ordered for private patients by a nurse practitioner.

3. Nurse practitioner initiated diagnostic studies will, in many cases, ensure that the patient receives optimal treatment quicker. For example;

   - Residential aged care facility residents assessed and treated by the nurse practitioner would not be required to wait for the weekly, or otherwise, visit of the GP to the facility. Likewise the busy GP will not be required to make a special visit to the facility to see the one patient requiring immediate assessment should the nurse practitioner have the ability to initiate diagnostic studies. This will have a positive effect on the GP’s time, reduce the impact on the other patients who are waiting in the surgery and will also be cost effective for the health industry. A good example of this working well would be a nurse practitioner assessing the patient as having a urinary tract infection and sending a urine specimen to the laboratory for microscopy, culture and sensitivity. They could
initiate medication and prevent admission of the patient before the sequela of sepsis, delirium and/or fall.

- Many patients who attend the emergency department are of a low acuity, ie Australasian triage Score 4 or 5. These patients are frequently left waiting in the waiting room of the emergency department for significantly longer periods than the recognised wait time of 1 and 2 hours respectively. Many of these patients are presenting for minor injuries that require some form of imaging, eg x-rays for suspected fractures of the upper and lower limbs. The ability of the emergency nurse practitioner to initiate required imaging for that group of patients will significantly improve the throughput of low acuity patients presenting to the emergency department.

- Wound management nurse practitioners are involved with the management of complex wounds that are often infected, or the patient has a co-morbidity that is impeding the healing process. The ability of the wound management nurse practitioner to initiate pathology studies such as wound swabs and other laboratory tests will lead to greater success in the healing process.

- Whilst nurse practitioners are currently initiating the above and other diagnostic studies it is often done in a convoluted and inefficient manner. The inefficiency usually involves the nurse practitioner having to contact the doctor and gaining permission for the test to be performed. In the absence of the doctor being on site requires further inefficiency as necessary paperwork is sent from site to site for necessary signatures.

- Nurse practitioners can prepare patients for admission to hospital from within the hospital, community and other convenient locations. This would free up pre-admission clinics and specialist medical care for the more complex patients.

- When responding to acutely unwell patients in the ward environment the nurse practitioner is able to order diagnostic tests in a timely manner and not have to rely on junior medical staff to attend to sign the form. This has particular relevance in rural and remote hospitals and after normal business hours and may prevent an admission to higher acuity care or facilitate it to occur more rapidly.

- Many rural centres have infrequent medical specialist attendance. The nurse practitioner orders all diagnostic screening with a view to maximising the patient journey through the health care system. This also cost effectively utilises skills of the health care team, including medical specialists. Anecdotal evidence has demonstrated that there are visiting doctors being paid large amounts of money to attend rural areas who are having to duplicate
and ‘sign off’ on the work (really just signing pathology forms and countersigning medication orders) of the nurse practitioner purely because the nurse practitioner is prevented from working to their full scope by having no access to Medicare. It is no wonder doctors are of the perception that they are responsible for the work of nurses.

9. Innovative and flexible health care delivery

The Evidence

Nurse Practitioner scope of practice is determined by the discrepancy between the patient need and what is available. This closes gaps in health care for vulnerable, marginalised, rural, remote and other client groups. This has particular applicability in closing the gap in Indigenous health status and that of other groups with identified needs.

- An example of innovative and flexible health care delivery is the Sexual Health Nurse Practitioner in the ACT who is playing an important public health role in the reduction of sexually transmitted infection and blood borne virus by providing clinical services in youth justice setting (majority is Indigenous), brothels and male sex on premise venues (O’Keefe & Gardner, 2003/4). This goes toward ensuring that access is on the basis of need, not ability to pay. Nurse practitioners are working in prisons and 'the prisoners now have immediate access to treatment and investigation,' (Davidson in Sweet, 2005). In this model nurse practitioners promote healthy lifestyles and prevent and intervene early in chronic illness such as hepatitis C.

- Another example of the provision of health services in rural areas for men in rural settings is evident with the men’s health model of nurse practitioner services. This model takes into account engagement strategies that are sensitive to men's need for timely access to care and is delivered in innovative locations such as local sale yards. (Strange, 2007)

- Sub acute care clinics can allow early discharge for patients from hospitals if there is a fast follow-up and problem solving clinic available. An example of this is the Sub-acute Pain Service (at RPAH Sydney) provided for patients to allow early discharge following surgery where pain management was a problem during the hospital stay.

- A paediatric care team working in the community is able to provide case management and various services to children. The team consists of paediatric nurse practitioners as well as allied health, with links to paediatricians. Care
can be provided through home visits and phone review to children classified in
four broad funding categories

- **Acute care follow-up**: 72 hour follow-up in the home of children discharged from hospital (or emergency) post acute illness – eg. asthma, fever.
- **Disability**: follow up for children requiring any of the nursing or allied health services and support (cerebral palsy requiring gastric feeds as well as OT input)
- **Personal health**: children who do not have a disability, but have chronic illness with complex needs (examples range from chronic lung disease needing oxygen to oncology children requiring antibiotics or subcutaneous injections to palliative care). This service is also able to provide a respite funding package.
- **Accident/compensation**: services can be provided to children who receive treatment for something due to an accident. A lot of wound management (like burns) can fall under this category.

Providing this service in the community results in a two way improvement in patient flow:

- Children who would usually be occupying a bed in the hospital with extended lengths of stay could actually be managed with support in their home through adequately trained staff. They would also not need to crowd emergency departments for procedures such as reinserting a nasogastric tube, because this service would be available in the community.
- Children who have acute illness that do not necessarily need to be admitted could be reviewed in the community.

- Nurse practitioners can also be part of a team of doctors and nurses to staff a 24 hour short stay unit in the community/or attached to a hospital, so often a child would progress through the system. One example is that if a child is reviewed by the team (after discharge), following the CAPCA model of care.

**Opportunities**

The opportunities for the implementation of nurse practitioners are limited only by the imaginations of consumers, the health workforce, policy makers and government. Where there is a gap in health care delivery and a nurse willing to extend their scope of practice there is an opportunity for success.

**Conclusion**

Nurse practitioners are senior clinical staff within their chosen specialty. They have many years of experience and work autonomously within an extended scope of practice. They have expert clinical skills that focus on the recognition of the health needs of the whole person within the context of their environment in a variety of settings. The nurse practitioner role supports existing patient care while increasing access to services for those people have not had access to care before.
Nurse practitioners work collaboratively within a multidisciplinary team, they make referrals for specialist medical care and to other health or community providers. They diagnose illness and prescribe medications. There is irrefutable evidence that they provide holistic, quality and timely care for patients.

The ANPA commends this evidence to the National Health and Hospitals Reform Commissioners for their consideration in reforming health care for the Australian community and makes the following recommendations.

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Support of nurse practitioner research initiatives including dedicated funding. This will assist in nurse practitioner workforce development and improvements in frontline patient care from prevention right through to chronic illness management.

**Recommendation Five- Funded nurse practitioner education**

Provision of national and other nurse practitioner education scholarship programs in line with strategic directions such as, but not limited to cardiovascular disease or aged care. This will help to provide a well qualified and sustainable health workforce into
the future.

**Recommendation Six-Community awareness and education program**

A coordinated and funded educational and awareness program through the media and other channels promoting the work of nurse practitioners and the value of choosing it as a career.

**Bibliography**


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Laurant, M; Reeves, D; Hermens, R; Braspennning, J; Grol, R; Sibbald, 2008. *Substitution of doctors by nurses in primary care*. Cochrane Database of Systematic Reviews.


