Joint Response from Nursing and Midwifery peak bodies on Scope of Practice (SoP) Issues Paper 2

To whom it may concern,

Thank you for the opportunity to make this joint response on behalf of the Australian College of Midwives (ACM), the Australian College of Mental Health Nurses (ACMHN), the Australian College of Nurse Practitioners (ACNP), the Australian College of Nursing (ACN), the Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM), the Australian Nursing and Midwifery Federation (ANMF), the Australian Primary Health Nurses Association (APNA) and CRANAPlus. Each of these organisations have approved and fully endorse this joint response.

Please note that many of these organisations have also submitted an individual response. The purpose of this joint response is to address common concerns and advice from the peak nursing and midwifery bodies in relation to some of the issues addressed by and arising from Discussion Paper 2.

As background to the role of nurses and midwives in Primary Health Care (PHC), the ANMF submission makes the point that nurses and midwives make up the greatest number of health professionals nationally and are the most widely dispersed across Australia. Indeed, in some regions a nurse and/or midwife will be the only health care professional (HCP) available. Nurses and midwives are educated to provide leadership autonomously, and/or whilst working in multi-disciplinary teams (MDT) (both locally, nationally and virtually). Many successful models of care exist and have been discussed and evaluated in previous discussion papers and submissions. These include models led (for example) by nurse practitioners (NPs), nurses, midwives, credentialed mental health nurses and endorsed midwives. Leading care through and within MDTs is intrinsic to nursing and midwifery practice, making them excellent examples of leaders in PHC. Nurse- and midwife-led PHC contributes to better health outcomes, fewer unplanned admissions, decreased incidences of complications and reduced levels of anxiety and depression. As an example, credentialed mental health nursing scope of practice is particularly aligned with the needs of people presenting with common conditions such as depression and anxiety in PHC. Evidence clearly shows that nurse-led PHC enhances a person's ability to self-manage and improves their quality of life, and midwife-led PHC provides better outcomes for women, newborns and families.

Overall, there is significant support for the ideas proposed in Issues Paper 2. However, it would be remiss not to acknowledge the level of mistrust that the politics of health might mean that the Government succumbs to the polished lobbying of the medical and psychological professional organisations (as has happened many times before). We urge the government to stand firm in relation to these reforms, as they will undoubtedly increase access to health care, particularly in rural, remote, marginalised, diverse and underserved communities. As a general principle and as stated in the ANMF submission, multidisciplinary teams (MDTs) do not need to be led by General Practitioners (GPs), a false assumption circulated by the media, medical peaks and other platforms, driven by MBS billing arrangements rather than care needs of the person seeking treatment, and alluded to in Issues Paper 2. This expectation has led to the significant lack of access to and affordability of PHC due to ever increasing costs imposed by GPs and is instrumental in the failure of the PHC system in Australia. Further, this situation has led to increasing privatisation of the PHC system in Australia with too great a reliance on business-based models of care that are driven by profits and the production of personal wealth. This focus means that, in some more rural and remote areas, the need to use the business model makes it too expensive for medical practitioners (and other HCPs) to actually establish a service. In addition, in some situations it is this very business model that makes rural practice unattractive and can either restrict consumer access to publicly funded best practice models of care or contrarily result in overservicing. This does not facilitate equitable or holistic access to care nor constitute leadership that ensures the person is at the centre of care.

The solutions such as the National Skills and Capability Framework and Matrix must apply to **all** HCPs equally, inclusive of the medical profession. In the past, there has been a tendency to treat medicine as separate and different from all other health professions, and thus to exclude them from requirements with which other HCPs have had to comply (see for example, the soon to be removed requirements for collaborative arrangements for nurses and midwives - a one way "collaborative" street). This has historically prioritised and privileged medicine, and disconnected medicine from the non-medical professions. The balance now needs to be restored.

PHC reform must be driven by safe, person-centred care that meets the needs of the people and the communities in which they live. To do this, clinicians must possess the expertise in a given context so they can deliver skilled and appropriate care. Despite the SoP review, recruitment of health practitioners must continue to be based on their education, knowledge, and experience, so that the person seeking PHC can access the right HCP with the right skills at the right time and in the right place. The SoP review should not be about introducing opportunities for less or inappropriately qualified or skilled HCPs or to meet the convenience of employers or institutions. Instead, it must be about strengthening all HCP capabilities tailored to the needs of communities, and the diversity within them.

This combined response also wishes to dispute the argument that is currently being leveraged by some medical groups about the prospect of fragmentation of care, should the recommendations of this review be implemented. Firstly, there is a section of the Australian community who do not or may not be able to access a regular GP and who might use both complementary and state-based emergency services as much as they would access general practice, sometimes for ideological reasons and sometimes for pragmatic access or fiscal reasons. Medical professionals are neither the arbiters of, nor do they have a monopoly on, continuity of care. Indeed, there is a strong argument that, even in current practice, nurses and midwives are often the hub of a patient's/ consumer's wheel that contains many medical/health spokes. Continuity of care is often facilitated by care navigator nurses, midwives and other nurses in the community, and nurse managers and clinical nurse consultants in hospitals. Susan Sontaag once wrote that we all travel at some stage in two kingdoms, the kingdom of the well and the kingdom of the sick[1]. If that is the case, then nurses and midwives are often the guides through those kingdoms, providing directions and interpretation as and when required. In rural and remote communities and with the marginalised and underserved, they are often the only guides, without whom there would be no continuity of care whatsoever.

Furthermore, supporting and employing a local nurse to become the local nurse practitioner (NP) or a Credentialed Mental Health Nurse (CMHN), or a local midwife to become endorsed, would provide greater sustainability and stability in continuity of care than an expensive fly-in medical service. Clearly this does not preclude the presence of a local GP who might work with a number of NPs/ CMHNs/endorsed midwives across a series of small towns. This would provide a strong service for the community, improve access and be cost efficient and effective. It would better utilise the unique skills and capabilities of each profession, supporting these autonomous and independent nurses and midwives in working to full scope, but also allowing the GP to focus on where their skills are needed and aligned with their own scope of practice. This should and can occur without limiting the SoP of other HCP, including nurses and midwives.

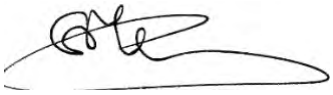
These logical arguments have been made repeatedly by nursing and midwifery (and allied health) groups, leaders, scholars and researchers, to consecutive governments of both persuasions, yet frequently ignored. Change has only ever been incremental, and in the case of autonomous nursing and midwifery roles, poor funding models have impeded sustainability and workforce growth, and led to significant under-remuneration and under-employment. Change in relation to the most autonomous roles in nursing and midwifery has always been greeted by apocryphal predictions from medical interest groups. To date, the sky has not fallen in when

[1] Sontaag S (2001) *Illness as metaphor and AIDS and its metaphors* Picador: New York

these changes have been implemented. However, the retention of some form of appeasement privilege for the medical profession within each change has meant that full scope of practice access for the public to highly qualified alternative HCPs such as credentialed mental health nurses, nurse practitioners, endorsed midwives and allied health professionals has been denied, and expensive locum and fly in medical cover has caused the taxpayer an unnecessary impost. It is to be hoped that this government will demonstrate the courage to implement the changes laid out in this evidence-based Discussion Paper.

Individual nursing organisations and colleges have separately provided detailed feedback to the questions raised in the Discussion paper 2, and it was felt that the joint response should address shared concerns as we look forward to working with the government to implement the reforms.

Yours sincerely



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