INCREASING ACCESS TO HEALTH AND AGED CARE: A STRATEGIC PLAN FOR THE NURSE PRACTITIONER WORKFORCE

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Consultation Draft

Submission from Palliative Care Australia

PalliativeCare AUSTRALIA

Introduction

Palliative Care Australia (PCA) is the national peak body for palliative care and represents those who work towards high quality palliative care for all Australians who need it. Working closely with consumers, our Member Organisations and the palliative care workforce, we aim to improve access to, and promote palliative care.

Response to the Australian Government Nurse Practitioner 10 Year Plan

PCA welcomes the opportunity to provide feedback on the *Consultation draft of the strategic plan for the nurse practitioner workforce (the Plan)*. Nurse practitioners (NPs) provide access to timely care that is holistic, cost effective and delivers good outcomes for patients. NPs are highly qualified, experienced and knowledgeable health professionals and all communities across Australia would benefit from access to NPs.

Palliative care NPs are a highly valuable and important part of the palliative care workforce and an important factor in addressing the growing palliative care needs of Australians. Palliative care NPs in both specialist palliative care services and primary healthcare support palliative care patients across the lifespan, from paediatric to ageing adults. Palliative care NPs provide effective outcomes, including reducing unnecessary hospitalisations and emergency out of hours care[1] and importantly, assist people to die in their place of choice.

PCA applauds the development of a draft plan that accurately reflects the barriers and opportunities that face the further integration of NP practice in the healthcare workforce. The feedback received during the first consultation round has clearly been incorporated into the Plan and the identified actions are evidence-based.

PCA would welcome any opportunities for further input to the Plan as it is finalised, and strategies are made for implementation.

Aim and Outcome of the Plan

PCA broadly supports the aim and stated outcomes of the Plan and agrees that the success of the Plan will be determined by how well the outcomes are achieved, through effective monitoring and evaluation. PCA supports the person-centred, culturally safe, and equitable approach of the Plan and the focus on sustainable workforce actions.

The targeted outcomes of the Plan are largely appropriate for the next 10 years, however PCA believes that the timeframes could be more ambitious for several of the actions. PCA recommends that actions relating to the aged care system under 3.2.2 and 3.2.3 should, where possible, be identified as short term actions, rather than medium term actions. The Royal Commission into Aged Care Quality and Safety's final report recognised that too few people receive evidence-based palliative care, and that palliative care should be core business for aged care providers. The Royal Commission also highlighted that increasing access to NPs in aged care would improve quality of care, and palliative care. PCA is of the view that there is urgency for further reform in aged care as

[1] Forbat L, Liu WM, Koerner J, Lam L, Samara J, Chapman M, Johnston N. Reducing time in acute hospitals: A stepped-wedge randomised control trial of a specialist palliative care intervention in residential care homes. Palliat Med. 2020 May;34(5):571-579. doi: 10.1177/0269216319891077. Epub 2020 Jan 2. PMID: 31894731.

Australia has an ageing population and KPMG's 2020 *Investing to Save* report predicts that the demand for palliative care will increase by 50% by 2035.[2]

1. Education Lifelong Learning

PCA commends the actions under section 1 of the Plan as these actions have the potential to support the NP workforce to enhance their skills and capability to address population health needs. In particular, PCA supports the actions that address financial barriers to accessing education and the communities of practice model to enhance the cultural safety of the workforce. PCA acknowledges that these actions have the potential to encourage and grow the First Nations NP workforce, however, systemic barriers in health services may act as barriers to the implementation and effectiveness of these actions.

PCA has received feedback that the number of accredited postgraduate NP programs within Australia has decreased in the last 10 years. As such PCA is concerned that many aspiring NPs need to study remotely and travel to attend mandatory face to face components of the course. PCA appreciates that the Plan acknowledges the need for remuneration for not just the course fees, but for travel and time including study leave. However, the need for professional development time is not always supported by employers, even if financial and other barriers are removed.

PCA understands that senior healthcare leaders may not consistently recognise the role of NPs and may not identify and provide access to educational pathways for potential NP candidates. Not all states and territories have NP candidates/transitional NP positions within their public sector enterprise agreements. In the ACT for example, there is no designated position for those studying towards a Masters to qualify as a NP.

PCA understands that the nursing workforce is comprised of a significant number of people working on a part-time basis. Applications for endorsement must demonstrate the equivalent of three years' full-time experience (5,000 hours) at the clinical advanced nursing practice level, within the past six years, from the date when the completed application seeking endorsement as a nurse practitioner is received by the Nursing and Midwifery Board of Australia (NMBA). PCA understand that it is difficult to demonstrate the required 5,000 hours when only working part-time. PCA suggests consideration of this issue as part of workforce planning for NPs.

While growing the NP workforce is vitally important, there needs to be secure NP roles created for the new NPs to be recruited into. These NPs need to be supported as they commence their NP career and are progressing towards being able to work to their full practice potential. While the Plan recognises of the value of the NP role within the workforce, it is essential that this is extended to new NPs so they experience recognition for their skills and contributions and that they have stable early career development and employment. NP roles need to be embedded and normalised within health services, they need to be funded and there needs to be a succession plan for sustainability.

2. Recruitment and Retention

PCA supports the actions under section 2 of the Plan and believes that achievement of these actions will facilitate the recruitment and retention of NPs.

PCA advocates that a public awareness campaign, as identified in action 4.1.1, is needed to deliver the actions identified regarding the recruitment and retention of NPs. As the Plan acknowledges,

[2] KPMG (2020), *Investing to Save – The economics of increased investment in palliative care in Australia*, retrieved from: https://palliativecare.org.au/publication/kpmg-palliativecare-economic-report/

there is a lack of public awareness and understanding around the role of NPs and this is a significant barrier to recruitment and retention. People will only request and access the services of NPs if they understand the role and how NPs can effectively support their health needs and increase the quality of care received.

Underserved populations who cannot or do not access a medical provider may benefit from a trusted relationship with a NP in their community. There are a number of barriers which limit an NP's ability to meet the needs of underserved groups including access to refer and request, limited time-based item numbers in the Medicare Benefits Scheme (MBS), limitations to initiating and prescribing medications on the Pharmaceutical Benefits Scheme (PBS) and the inability to prescribe with the Repatriation Pharmaceutical Benefits Scheme (RPBS), sustainable cost model. An inability for NPs to work to their scope of practice and fulfill a patient's needs can lead to negative patient and community outcomes. An example of this is the inability of palliative care NPs to complete death certificates, even if they have been the primary provider of end-of-life care and prescriber of medications. Further, regional and remote Australia would benefit from access to NPs. There is a risk, however, that in the absence of an effective educational campaign, communities may not be aware of, or recognise, the scope of practice of the NP, particularly if the NP is operating in a setting without other medical staff.

Inadequate awareness and understanding of the role of NPs is not limited to the public; other health professionals and employers can act as a barrier to recruitment and retention through inaccurate perceptions about NPs' scope of practice. The Workforce Incentive Program (WIP) Practice Stream is an example of an incentive program that could be expanded or replicated to focus on specific needs such as palliative care. Incentive programs such as the WIP can help to overcome cultural barriers to NP integration in the workforce.

PCA commends action *3.2.1 Explore reviewing arrangements that enable NP prescribing of medications to ensure alignment with legislation.* NPs working in remote and regional communities are particularly challenged by inconsistent medicines and poisons legislation in the states and territories they work in. PCA received feedback from a palliative care NP who works across residential aged care facilities (RACFs) across two cities, which are part of the same regional community, however the NP must ensure they understand the separate legislation across the different jurisdictions when prescribing. The NP also noted that they are limited by the need for one of the state's requirements to work within an approved formulary. These legislative restrictions need to be standardised so that endorsed NPs can practice seamlessly across borders.

PCA supports the aim of action 3.2.1 *Remove inappropriate variations and limitations on NPs' ability to prescribe medications across jurisdictions*. NPs working in palliative care must have access to initiate and prescribe as continuing therapy all essential palliative care medicines, including all Schedule 8 opioids and Schedule 4D medicines.

PCA advocates for a trial of a blended payment systems model. The Plan references on page 18 under *2.1 Actions to facilitate recruitment and retention of nurse practitioners* "revising the structure and breadth of NP MBS items" however, PCA is concerned that this will be insufficient to provide secure and sustainable work for NPs. Palliative care NPs in particular need a different model as they are often working across community and primary healthcare. As such, PCA suggests consideration of a trial of a blend of salary and MBS funding to enable security. At a minimum, palliative care NPs must be able to access MBS items for extended consultations (greater than 60 minutes) and for organising and facilitating multidisciplinary case conferences and advance care planning. This should enable more people to die at home with the end-of-life care that they need. If NPs are secure in

their jobs and know that their employment is reasonably stable, then retention rates should increase. Implementing models of care that allow NPs to be employed in the public sector while simultaneously having the right to private practice should improve job satisfaction and retention while increasing access to NP care.

3. Models of Care

PCA is supportive of the actions to facilitate sustainable models of NP care as these actions could help to meet community needs. PCA welcomes the actions aimed at ensuring national consistency of practice and enabling NPs to work to their full scope of practice. PCA strongly supports the broadening of the role of NPs to allow the full scope of practice to be delivered. However, there will always be a need for specialist palliative care NP roles to provide complex patient case management across community, residential care settings or hospitals.

PCA welcomes the acknowledgement in the Plan of existing MBS parameters influencing the financial viability of private practising NPs. Funding models and poor renumeration from the MBS prevents NPs from setting up practice in the community, instead they elect to remain in state/territory funded hospitals on a guaranteed salary or to work outside of NP specific roles. There needs to be a recognition of NPs through credentialling their scope of practice to allow for improved access to MBS and PBS/RPBS. Similarly, there needs to be parity in the MBS funding arrangements for NPs with their medical provider colleagues when providing care.

The fee for service model is not always appropriate for palliative care. A blended funding arrangement is also needed to secure palliative care NPs to a geographic location or service.

4. Health Workforce Planning

PCA believes that the actions under section 4 of the Plan have the potential to build understanding of the role and contribution of NPs for consumers, health professionals and employers. In particular, PCA welcomes the NP awareness strategy to support the Plan (4.1.1) and the nationally consistent minimum data set and workforce modelling (4.2.1 and 4.2.2) that will enable workforce planning and projections. PCA understands the importance of evidence-based planning to address critical workforce shortages to ensure changing population needs can be met. In the palliative care space this will only grow in the coming decade and the health system will not be able to meet expected need unless change is implemented now. PCA supports the timeframes of the actions for health workforce planning.