Supplementary Submission to Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

May 2017
**Introduction**

The Queensland Nurses and Midwives’ Union (QNMU) thanks the independent Reviewer, Professor Michael Woods, for the opportunity to make a supplementary submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (the review).

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing and midwifery workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 57,000 members work across a variety of setting from single person operations to large health and non-health institutions, and in a full range of classification from entry-level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU.

**Submission Context**

The Australian Nursing and Midwifery Federation (ANMF) made a submission to the review on 1 May 2017.

On the 16 May 2017, Professor Michael Woods attended the ANMF Federal Executive meeting to discuss the progress of the review. Based on discussions at this meeting, the opportunity for ANMF branches to provide supplementary submissions was granted.

The QNMU, as a branch of the ANMF, has taken the opportunity to provide a supplementary submission. In doing so, we wish to focus our feedback on section 5 Producing the future health workforce of the review’s discussion paper dated February 2017.
Section 5 Producing the future health workforce

Setting health workforce reform priorities

The QNMU considers there is a vital role for the governance bodies of the National Registration and Accreditation Scheme (NRAS) to assist and/or facilitate wherever possible the achievement of health workforce reform priorities for nursing and midwifery.

As outlined in the ANMF’s submission dated 1 May 2017, the nursing and midwifery professions include a wide range of stakeholder groups that provide advice on agendas and reforms across education, industry, industrial, professional, regulatory and community perspectives [1]. The QNMU considers it unreasonable to expect any individual nursing and/or midwifery stakeholder group to speak on behalf of all nursing and midwifery stakeholders regarding reform priorities. This is because each nursing and midwifery stakeholder group has distinct knowledge and expertise about professional practice.

Therefore, the QNMU recommends a comprehensive nursing and midwifery stakeholder engagement and consultation framework is developed. This will ensure governance bodies in the NRAS remain well informed of current and emerging reform priorities for these professions.

Recommendation 1:
The QNMU recommends a comprehensive nursing and midwifery stakeholder engagement and consultation framework be developed for the various governance bodies in the NRAS.

Reform agenda for nursing and midwifery

The QNMU considers the main priorities in nursing and midwifery health workforce reform involve the development and operationalisation of strategies that enable nurses and midwives to:

- work to their full scope of practice across all settings;
- expand the delivery of nursing and midwifery across the healthcare system to increase service capacity and consumer choice;
• increase nursing and midwifery services to improve the effectiveness and efficiency of the healthcare system;
• provide high-performing nursing and midwifery services through continual learning and evidence-based practice; and
• enhance patient/consumer care through access to appropriately designed data sets and information systems [2, 3, 4, 5, 6].

To achieve these priorities, it is necessary to adopt a multifaceted approach to the reform process in a number of areas including legislative frameworks, administrative practices, funding models, policy agendas and organisational custom and practice [3, 5, 6, 4, 2, 7, 8].

A fundamental reform priority is to expand the public/private service provider frameworks and funding models to include registered nurses and midwives, particularly in the areas of Pharmaceutical Benefits Scheme (PBS), Medical Benefits Schedule (MBS) and private insurance schemes. The inclusion of registered nurses and midwives in public/private service provider frameworks increases the capacity of healthcare services to meet consumer demand by reducing the preferential financial support for medical models of practice over nursing and midwifery models of care.

At present, in the majority of healthcare interactions a medical officer must be appointed as the primary healthcare provider if healthcare organisations want to be fully funded for services provided, or if consumers want to obtain full rebates for services received.

The inequitable access to public/private service provider frameworks and funding models has produced perverse financial incentives, which have driven the majority of Australian healthcare services and consumers to only consider medical officers as primary healthcare providers. This bias towards medical officers has resulted in registered nurses and midwives being underutilised in the healthcare system even though evidence indicates they are capable of providing the same, if not better, outcomes for consumers than their medical colleagues [2, 9, 7, 10, 8, 11].

An inclusive service provider framework and funding model is possible as exemplified by the Council of Australian Governments (COAG) improving access to primary care in rural and remote areas Section 19(2) exemption initiative. This initiative provides for exemptions under Section 19(2) of the Health Insurance Act 1973 (the Act) to allow eligible sites to claim
against the MBS for non-admitted, non-referred professional services, which includes nursing and midwifery services provided in emergency departments and outpatient clinic settings [1]. The initiative originated from the need for public hospitals to provide primary health services to rural and remote towns due to the lack of private General Practitioner services [1].

There are many QNMU members working in Queensland Health services that apply the Section 19(2) exemption, in fact, Queensland has 32 exempt hospitals making it the state with the highest number of exemptions in Australia [1]. It is obvious, as the largest clinical workforce, that nurses and midwives are providing significant levels of primary health services to rural and remote Queenslanders [13]. These services are considered safe and of high quality, which begs the question; why registered nurses and midwives are not included in the general MBS and PBS servicing framework in the first place?

The table below provide a summary of the projected key benefits that would be produced if nurses and midwives were included more in public/private service provider frameworks and funding models.

**Figure 1: Impact inclusive service provider frameworks and funding models**

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<tr>
<td>Increasing consumer demand</td>
<td>• increase in availability of primary healthcare providers</td>
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<td>• improvements in the capacity of healthcare services to meet demand</td>
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<td>Increasing consumer expectations</td>
<td>• increase in consumer choice</td>
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<td>• decrease in wait times</td>
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<td>Increasing burden of chronic disease</td>
<td>• increase in consumer access to appropriately skilled healthcare providers</td>
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<td></td>
<td>• increase in the capacity of health promotion and prevention services</td>
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<tr>
<td>Achieving equitable health outcomes</td>
<td>• increase in access to healthcare providers in rural &amp; remote communities</td>
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<td></td>
<td>• increase capacity to meet the healthcare needs of Aboriginal &amp; Torres Strait Islanders</td>
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<tr>
<td>Developing a productive health workforce</td>
<td>• increase in the productivity of healthcare services</td>
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<td></td>
<td>• increase in the integration of healthcare services</td>
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<tr>
<td>Utilising data and evidence to drive value</td>
<td>• provision of evidence-based contemporary healthcare services</td>
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<td>• increase in the effectiveness and efficiency of healthcare services</td>
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The QNMU believes the development of appropriate nursing and midwifery data sets at the national level will facilitate positive reform for nurses and midwives across the legislative, administrative, funding, policy, and custom and practice frameworks. Minimum nursing/midwifery data sets collect specific information about the structure, process and quality outcomes of nursing and midwifery care [15, 16]. They are often used to demonstrate how nurses and midwives add value in the healthcare system [15, 16].

In Australia, healthcare performance data sets are predominately aligned to meet the reporting requirements of generic macro-level funding models [17]. The generic nature of these data sets is problematic, as the data produced does not adequately represent the contribution of nurses and midwives as the largest clinical workforce [18]. The QNMU considers the development of specifically designed data sets and information systems a major reform priority for the nursing and midwifery health workforce [19]. As such, we recommend the governing bodies of the NRAS contribute to the reform agenda relating to nursing/midwifery data collection and information systems.

**Recommendation 2:**
The QNMU recommends consideration is given to how the governing bodies of the NRAS can be supported to respond/contribute to reform agenda items identified by the nursing and midwifery professions involving legislative, administrative, funding, policy, and custom and practice frameworks.

**Recommendation 3:**
The QNMU recommends consideration is given to how the governing bodies of the NRAS can be supported to respond/contribute to the further expansion of public/private service provider frameworks and funding models to include nurses and midwives.

**Recommendation 4:**
The QNMU recommend consideration is given to how the governing bodies of the NRAS can be supported to respond/contribute to reform priorities in nursing and midwifery data collection and information systems.
Case Studies

The case studies below provide practical reflections of why the health workforce reform agenda is so important to nurses and midwives working in Queensland. The examples are indicative of the restrictive environment being experienced by nurses and midwives on a daily basis.

*Rural and Isolated Practice Endorsed Registered Nurse (RIPERN)*

A RIPERN is a registered nurse who has met the Nursing and Midwifery Board of Australia (NMBA) registration standard for endorsement for scheduled medicines – rural and isolated practice [16]. RIPERNs may practise in isolation or in collaboration with other health professionals in areas such as rural and remote hospitals, remote area emergency sites, mining sites, indigenous communities, tourist resorts, and remote pastoral stations. Predominately, RIPERNs work in locations where onsite access to medical practitioners and/or nurse practitioners is by visit only or not available at all.

The RIPERN endorsement, as per Section 94 of the *Health Practitioner Regulation National Law Act 2009* (the National Law) qualifies a RIPERN to obtain, supply and administer limited schedule 2, 3, 4 or 8 medicines appropriate to their scope of practice. This is to the extent necessary to practise nursing in a particular area and within the confines of a Chief Health Officer standing order or health services permit that must be compliant with relevant State and Territory legislation [16]. The services provided by RIPERNs meet the eligibility criteria for the MBS and the PBS.

In Australia, there are approximately 1,100 RIPERNs endorsed to provide emergency and primary healthcare to an advanced and/or expanded clinical scope of practice to patients in rural and remote areas [17]. Queensland has the largest number of RIPERNs with 836 found on the register [17]. In 2016, the NMBA proposed the discontinuation of the Registration standard: Endorsement scheduled medicines (rural and remote practice). The outcome of NMBA’s proposal is still pending; however, the QNMU strongly opposes the discontinuation of this endorsement, as it places Queensland’s rural and remote primary healthcare services at risk of not being able to meet the health demands of their communities.
RIPERNs contribute to public safety and provide evidence-based quality care for people living and working in rural and remote communities across Queensland [22]. The withdrawal of this endorsement would significantly reduce the numbers of staff available to supply medicines in these vulnerable locations. An alternative solution to the loss of RIPERNs is transition to nurse practitioner positions.

Nurse practitioners have access to MBS and PBS and are capable of providing high levels of clinically focused autonomous nursing care in a variety of contexts in response to varying patient/community complexities [18]. The contribution of nurse practitioners to the healthcare system is extensive and well proven [7]. However, workforce mapping in Queensland has demonstrated there are insufficient numbers of nurse practitioners to replace the RIPERN positions presently employed. This is due to the lengthy time it takes for nurse practitioners to become educationally prepared and competent for practice.

To support the sustainability, continuity and quality of healthcare in rural and remote communities, the QNMU believes the following fundamentals are necessary:

- the existence of an NMBA endorsed program of study that enables registered nurses and midwives to be educationally prepared and competent to supply medicines to consumers under the PBS, as well as, request diagnostic tests under the MBS;
- the list of rural and remote hospitals eligible for the Section 19(2) exemption requires expansion to align with growing demands within regional, rural and remote communities; and
- the development of a national health professionals prescribing pathway inclusive of core prescribing competencies for registered nurses.

**Midwifery**

In July 2016, the QNMU surveyed midwifery members about their work [24, 25]. The survey revealed some unexpected results, which included a strong response rate from 75.2% of the eligible midwives in the state of Queensland - this represents 60% of the entire eligible midwives workforce of in Australia [16, 17]. Survey results indicated that over 50% of eligible midwives were not working to full scope of practice due to being engaged in restrictive models of care where they were not able to access Medicare or use their prescribing endorsement.
In January 2017, the standard for ‘eligible’ midwives was altered to create a one-step process requiring all midwives who seek a Medicare provider number to obtain an endorsement for scheduled medicines [25]. The 130 midwives who were notated as ‘eligible’ are now required to join the 278 midwives who have an ‘endorsement for scheduled medicines’ [21]. This transition must occur within 18 months or the ‘eligible’ midwives will lose their ability to access a Medicare provider number. However, the motivation for ‘eligible’ midwives to undertake coursework to become ‘endorsed’ is low as the vast majority of these midwives are employed within state healthcare services where they are unable to use their endorsement due to restrictive models of maternity care.

The mechanism to enable use of the MBS by midwives exists using the Section 19(2) exemption pathway model as outlined above. If applied more broadly, the exemption pathway would allow midwives providing primary maternity care to increase the funding prospects for healthcare services through developing own source revenue models. Own source revenue models for midwifery services have been recognised by a number of national maternity care reviews as a viable funding option for health services. Recommendations have been made to increase midwifery own source revenue options within the reform agenda however, little progress made on this issue.

The QNMU considers the failure of the healthcare system to utilise midwives to their full scope of practice is limiting consumer access to evidence-based maternity models of care, which is a problem critically in need of reform.

**Recommendation 5:**

The QNMU recommends consideration is given to how the governing bodies of the NRAS can be supported to respond/contribute to reform priorities specific to regional, rural and remote communities, including:

- increasing access to the MBS and the PBS for nurses and midwives;
- expanding the list of hospitals eligible for the Section 19(2) exemption; and
- developing a national health professional prescribing pathway inclusive of registered nurses.
Summary

As the largest group of healthcare providers, nurses and midwives are well placed to address the rising challenges of complex health demands being faced by the healthcare system. To achieve this successfully, the legislative, administrative, funding, policy, and custom and practice frameworks that guide and support healthcare delivery must support, not restrict, nurses and midwives working to their full potential. All stakeholders involved in the healthcare system, including the governing bodies in the NRAS, have a responsibility to respond and contribute to health workforce reform priorities. However, it is important for governing bodies to gain a thorough understanding of the reform priorities through appropriate engagement and consultation processes. In the case of the nursing and midwifery professions, this means committing to seeking advice on the health workforce reform agenda from a wide range of stakeholders across diverse settings and environments.
Reference List


