Australian Nursing & Midwifery Federation

16 September 2022

Professor (Practice) Alison McMillan
Commonwealth Chief Nursing and Midwifery Officer
Australian Government Department of Health and Aged Care
GPO Box 9848
Canberra ACT 2601

Via email: *alison.mcmillan@health.gov.au;*
CNMO@health.gov.au

Dear Alison,

Re: Independent Review of Collaborative Arrangements

Thank you for the opportunity to provide a written submission for the Independent Review of Collaborative Arrangements.

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 320,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Canberra Office
Unit 3, 28 Eyre Street
Kingston ACT 2604
Australia

T +61 2 6232 6533
F +61 2 6232 6610
E anmffederal@anmf.org.au
W www.anmf.org.au

Melbourne Office
Level 1, 365 Queen Street
Melbourne VIC 3000
Australia

T +61 3 9602 8500
F +61 3 9602 8567
E anmffederal@anmf.org.au
W www.anmf.org.au

ANMF Journals

Australian Nursing and Midwifery Journal (ANMJ)
E anmj@anmf.org.au

Australian Journal of Advanced Nursing (AJAN)
E ajan@anmf.org.au

ABN 41 816 898 298

Nurse Practitioners

Nurse practitioner roles were introduced in Australia more than 30 years ago with a range of objectives including improved access to health care services via a flexible, innovative, integrated care strategy, and increased continuity of nursing care at an advanced practice level.

Nurse practitioners have improved primary health care access for marginalised, disenfranchised, and geographically isolated populations, whilst providing nursing expertise in a broad range of settings such as aged care, palliative care, cardiac health, mental health, pain management, alcohol and other drugs, and renal replacement therapy. Extending the services nurse practitioners can provide has reduced fragmentation of care by facilitating comprehensive assessment, evaluation, and treatment. It also offers increased opportunities to initiate health promotion discussions and disease prevention activities, thereby reducing the development and progress of preventable health conditions.

Participating midwives

Midwives are competent, collaborative, and safe practitioners. They are a regulated workforce, and as such are responsible at law for the extent and scope of their practice. At all levels of practice, midwives are adept at recognising where the knowledge, expertise and skills of their colleagues are required, then referring to, and liaising with, other team members across health professions. This is a foundational component of midwifery practice and is articulated in the NMBA *Midwife standards for practice* and the Code of conduct for midwives. Midwives are well educated, highly skilled and competent clinicians in their field of expertise.

Regulation

Regulation of nurse practitioners and midwives by the Nursing and Midwifery Board of Australia (NMBA) under the *Health Practitioner Regulation National Law Act 2009* [1](the National Law) is the appropriate mechanism to protect the public. The titles 'Nurse practitioner' and 'midwife' are protected under the National Law, making it an offence for use of these titles by anyone other than those authorised to do so by the legislation.

Endorsement to practice as a nurse practitioner is vested in the NMBA. To be eligible for endorsement as a nurse practitioner, an applicant must meet the NMBA *Registration Standard: Endorsement as a Nurse Practitioner*. The minimum educational preparation for nurse practitioners is a Masters of Nurse Practitioner program accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA. Nurse practitioners

[1] Parliament of Australia (2010) Health legislation amendment (midwives and nurse practitioners) Bill 2009 Bills digest no. 11 2009-10. Commonwealth of Australia. Accessed 12 September 2022 from https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd0910/10bd011#Purpose

practice in all clinical areas, across metropolitan, rural and remote Australia, in both the public and private sectors. Their practice is supported by relevant legislation. All nurse practitioners must meet the NMBA *Nurse practitioner standards for practice*.

As registered nurses and midwives, all endorsed nurse practitioners and participating midwives practice under the NMBA professional practice framework. This national framework includes: the relevant standards for practice; the codes of conduct; the codes of ethics; the decision-making framework; the safety and quality guidelines; and the national registration standards for criminal history, English language skills, continuing professional development, recency of practice, professional indemnity insurance arrangements, endorsement as a nurse practitioner and endorsement for scheduled medicines for midwives.

There should be no requirement for further jurisdictional or organisational criteria, credentialling, certification or collaborative arrangements for nurse practitioner or participating midwives practice. This only serves to create additional unnecessary, inefficient, frustrating processes and a further barrier to nurse practitioner and participating midwife scopes of practice, already well-regulated as detailed above.

No other regulated health practitioner under the National Law, including medical practitioners, have a legislated, mandated requirement to 'ensure' collaboration. Collaboration is not a matter of public protection or professional practice as they are the remit of the NMBA.

Rationale for collaborative arrangements

The objective of nurse practitioner and participating midwife access to the MBS and PBS was to support better access to high quality nursing and maternity care and choice of health care provider.[2] The requirement for collaborative arrangements has created a significant barrier to these aims.[3]

The requirement for mandated, legislated collaborative arrangements with a medical practitioner when access was granted to the MBS and PBS for nurse practitioners and participating midwives services was the result of doctor's concerns expressed more than a decade ago about fragmentation of care.[4] [5]

[2] Ibid
[3] National Health and Hospitals Reform Commission. (2009). *A Healthier Future for All Australians - Final Report of the National Health and Hospitals Reform Commission.* s.l. : Commonwealth of Australia, 2009. ISBN: 1-74186-940-4.
[4] Cashin, A. (2014). *Collaborative arrangements for Australian nurse practitioners: A policy analysis.* Journal of the American Association of Nurse Practitioners, 2014, Vol. 26(1): 550-554.
[5] Australian Medical Association. (2022). *Collaboration between nurses and doctors key to best patient care.* Accessed 12 September 2022 from https://www.ama.com.au/index.php/ama-rounds/21-january-2022/articles/collaboration-between-nurses-and-doctors-key-best-patient-care

In the case of nurse practitioners, this was based on a limited understanding of their education, experience and scope of practice. Nurse practitioners are qualified health practitioners, subject to regulation, and legally accountable for practicing within their scope of practice, which is determined by their education, experience, practice setting, and role.

Whilst the underlying premise of mandating collaborative arrangements was to reduce fragmentation of care, safeguard the person receiving care, and facilitate collegial professional communication between nurse practitioners and participating midwives and their medical colleagues, this has not been the result in practice.

In reality it is all about turf protection and control, or loss of it, and it needs to be called out as a monopolistic and predatory market practice that would be subject to ACCC intervention if it was in any other sector of the economy.[6]

Dealing with one primary health provider, who in turn consults with and refers to other health care providers, reduces the risk of conflicting advice or clinical decision making based on an incomplete picture and facilitates a professional relationship between the person receiving care and the health practitioner. The holistic knowledge and skill of the nurse practitioner and participating midwife enhances the provision of continuous care for the person as they move between contexts of practice and settings and with other colleagues input where required.

If indeed there is concern about fragmentation of care, why then are general practitioners not required to collaborate with their specialist medical practitioner colleagues under a legislated, mandated collaborative arrangement?

Appropriateness and effectiveness of collaborative arrangements

The ANMF strongly supports collaboration but strongly opposes the current collaborative arrangements as they do not facilitate true collaboration. They are neither appropriate nor effective and have been a consistent barrier to nurse practitioners and participating midwives providing their expert care to people living in Australia.

[6] Royal Australian College of General Practitioners. *RACGP Response to the Review of Collaborative Arrangements*. June 2022. fragmentationhttps://www.racgp.org.au/getmedia/e6a46a33-c005-48cc-a57e-7f7fd7b81853/RACGP-Nurse-Practitioner-Survey-Response.pdf.aspx.

Collaboration is defined as working together for a common purpose to achieve a benefit. True collaboration is based on mutual trust and respect. Mutual trust and respect are widely recognised in the literature as essential for the development of interdisciplinary collaboration.[7]

An unintended consequence of this mandated requirement has been that the resulting arrangements are in fact anti-collaborative and have not promoted safe practice, genuine collaboration, or appropriate mentorship. This appears to have occurred because the named collaborating medical practitioner has, in many cases, viewed the arrangement as a formality which, once acknowledged on paper, did not progress to case discussion or mentoring. In other cases the collaborating medical practitioner has interpreted the position as one of supervision and responsibility for another practitioner's practice, regarding the nurse practitioner or participating midwife as a subordinate rather than an autonomous health practitioner in their own right, thereby reducing their capacity to wholly inhabit the role. This misunderstanding of the intent of a formalised collaboration has had a negative impact on employment arrangements, as some medical practitioners have misconstrued their obligation and determined that they have neither time nor resources to 'oversee' a practitioner from another discipline.

The result is that, rather than leading to a mechanism which supports effective liaison between nurse practitioners and participating midwives and their medical colleagues, the stipulation of mandatory collaboration has led to delays in treatment, increased fragmentation, reduced utilisation of nurse practitioners and participating midwives, and poorer access to care.

Health practitioner colleagues, including medical practitioners, do not carry responsibility for the practice of a nurse or a midwife. While nurse practitioners and participating midwives work in collaboration with their colleagues, they are never supervised in their clinical practice by medical colleagues, nor by any other non-nurse or non-midwife health practitioner.

The reliance on the good will of the collaborating medical practitioner places the nurse practitioner and participating midwife in a dependent position, rather than on an equal professional footing. Such an arrangement is utterly at odds with the premise of these roles. Collaborative arrangements have allowed medical practitioners to approve or veto whether people are able to claim MBS rebates from care provided by nurse practitioners and participating midwives.[8]

Collaborative practice should be based upon mutual trust and respect. There must be a two-way commitment to collaboration. It does not mean one profession dominating or overseeing

[7] Virani, T., *Interprofessional collaborative teams*, Canadian Electronic Library. 2012. Retrieved from https://policycommons.net/artifacts/1201261/interprofessional-collaborative-teams/1754381/ on 12 Sep 2022. CID: 20.500.12592/j47p09.

[8] Medicare Benefits Schedule Review Taskforce. (2019). Post Consultation Report from the Nurse Practitioner Reference Group. Accessed 12 September 2022 from https://www.health.gov.au/resources/publications/final-report-from-the-nurse-practitioner-reference-group

another. It means respecting each other's expertise, autonomy and responsibility in shared decision making.

The collaborative arrangement requirement infers that nurse practitioners and participating midwives are in a subservient position rather than in a collegial position with medical practitioners when providing collaborative care. Current legislation requiring nurse practitioners and participating midwives to form collaborative arrangements is antithetical to legitimate collaboration and disregards the autonomy and responsibility inherent in the professional standards for practice.[9]

It is the right of the person receiving care to choose the health practitioner they wish to be involved in their care. Requiring people to consult with a medical practitioner to access the MBS for a nurse practitioner's or participating midwife's services does not respect this right to choose.

As many participating midwives find it difficult to secure a collaborative arrangement with one medical practitioner for all women in their care, they must ask each individual woman to seek a referral that fulfils the collaborative arrangement requirement. Women often need to shop around to secure a referral or consult with a medical practitioner that is not their usual care provider. Not only does this contribute to fragmented care, it costs the health care system and forces women to consult with a medical practitioner, regardless of whether they wish to do so.

Feedback from our members demonstrates the unnecessary barriers collaborative arrangements create:

> *A woman came to see me with a change in her breast; her GP is male, and she didn't want to see him for women's health issues. I completed the work up with a history and clinical breast exam and, in accordance with national guidelines, needed to refer her for a diagnostic mammogram and ultrasound. As I can't order these myself, I gave her the choice of being referred to the collaborating GP, or to her own GP, for these tests – for which she had to pay another consultation fee. The ultrasound detected a mass, with a fine needle biopsy recommended. Again, I needed to either get the collaborating GP to request the test, or refer the woman back to her GP and hope the GP will do the follow up. Either way means delay, additional anxiety, and fragmented care for the woman. – Nurse practitioner (NSW)*

[9] Schadewaldt, V., McInnes, E., Hiller, JE & Gardner, A. (2016) *Experiences of nurse practitioners and medical practitioners working in collaborative practice models in primary healthcare in Australia – a multiple case study using mixed methods.* BMC Family Practice, 2016, Vol. 17. https://doi.org/10.1186/s12875-016-0503-2.

> *I still have GPs refuse to refer pregnant women to our care despite the known benefits to woman and baby of continuity of midwifery care, a long career, earning a Bachelor and a Masters of Midwifery, and a postgraduate course in pharmacology screening and diagnostics, in addition to my experience as a lead maternity carer with a caesarean section rate of 2%, only two inductions of labour in the last four years, no stillbirths, no preterm births, and minimal PPH neonatal resuscitation and transfer to hospital. I have insurance, but the need for GP referral and collaboration with some hospitals that wrote back to us on each occasion with a letter advising that they will not collaborate with us. – Participating midwife (Qld)*

Locating available, accessible medical practitioners with whom nurse practitioners and participating midwives can create a collaborative arrangement has proven difficult in settings where access to health care practitioners is already reduced, particularly remote and very remote areas.[10]

Collaborative arrangements do not align with these core elements of nursing and midwifery practice. There is insufficient evidence to support their use and they create an unnecessary burden on nurse practitioners, participating midwives and those for whom they provide care.

Genuine collaboration

Nurse practitioners and participating midwives want genuine collaboration, while also working autonomously within a team environment. They recognise that real, meaningful collaboration contributes to better health outcomes for those for whom they provide care. Removing the legislated requirement for a collaborative arrangement will not reduce nurse practitioners or participating midwives willingness to confer with their multi-disciplinary colleagues. Removing this provision will, however, contribute to a health care system that is able to capitalise on the full potential of nurse practitioners and participating midwives, whilst also creating an environment that facilitates mutually beneficial, genuine multi-disciplinary consultation, collaboration, and where appropriate, mentorship. Making that change will result in the provision of better, more integrated, safer care.

Better utilisation of nurse practitioners and participating midwives offers clinical, economic and public health benefits including but not limited to increased access for people, increased choice of care provider, and improved continuity, coordination of care and case management as well as avoiding duplication and fragmentation of care. These benefits are not being realised.

[10] Currie, J, Chiarella, M & Buckley, T. (2017). *Collaborative arrangements and privately practising NPs in Australia: results from a national survey.* Australian Health Review, 2017, Vol. 41(5): 533-540.

Removing the collaborative arrangement will ensure nurse practitioners and participating midwives are able to utilise their full scopes of practice, aligns with evidence-based high quality health care, increases the accessibility of health practitioners, increases the availability and choice of care provider, avoids duplication and fragmentation of care, improves the continuity and coordination of care, reduces the cost of health care, and prevents delays to diagnosis and treatment.

Removing this provision will foster a collegial relationship of mutual trust and respect, with shared decision making, and help to create an environment of true multi-disciplinary consultation and collaboration.

To this end, it is essential the legislative mandated requirement to form collaborative arrangements is removed. It is neither appropriate nor effective and prevents access to high quality evidence-based health care for people in Australia.

Should you require further information on this matter, please contact Julianne Bryce, Senior Federal Professional Officer, ANMF Federal Office, Melbourne on 0409 221 699 or jbryce@anmf.org.au.

Yours sincerely

Annie Butler
Federal Secretary