Submission by the Australian Nursing and Midwifery Federation

Unleashing the potential of our health workforce. Scope of practice review. Response to Issues Paper 2

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Introduction

1. 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 326,000 nurses, midwives and care-workers across the country.
2. 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.
3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides 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.
4. 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.
5. The ANMF welcomes the opportunity to provide feedback on *Unleashing the potential of our health workforce Scope of Practice Review: Issues Paper 2*.

Overview

6. The independent review into the scope of practice of health professionals working in primary healthcare (PHC) in Australia offers a once in a generation opportunity to improve access to PHC for all people living in Australia. The work on the Review to date is encouraging in moving toward a healthcare system that ensures nurses and midwives can work to their scope of practice alongside other health practitioners.

7. Several options put forward in Issues Paper 2 are supported by the ANMF but with such sweeping suggestions for change, there are instances where additional information would assist in helping health practitioners and other stakeholders to understand more fully the possible consequences and impacts on healthcare and the nursing and midwifery workforce.

8. Working in multidisciplinary teams (MDT) and providing evidenced based, person-centred care is and has long been, inherent to the work of nurses and midwives and fundamental to their pre and post registration education. Of equal importance is ensuring the professional identities of nursing and midwifery are not lost or subsumed into a generic healthcare worker role. Nurses and midwives must continue to deliver and lead discipline specific education, generate evidence and knowledge and be instrumental in the evolution and development of the profession.

Leadership and primary care

Q. 1 What leadership do you consider important to ensure reforms are successfully implemented? For example, what is required at the professional, practice, organisation and/or profession level?

9. The ANMF supports the broad aims of the Scope of Practice Review and Issues Paper 2, to ensure equitable access to primary healthcare (PHC) by enabling health practitioners to work to and expand their scopes of practice. Nurse and midwife leadership must be recognised at all levels of the healthcare system. Given nurses and midwives make up the largest number of healthcare professionals across Australia, they will be instrumental in ensuring the success of any planned implementation of reforms.

10. Nurses and midwives must be a part of planning and decision making in all sectors. This will require collaboration with nurse and midwife peak bodies, unions, professional organisations, education providers and practitioners in decision making processes around reform. There must also be recognition of nurse and midwife led models of care and the essential and integral role they already play in PHC.

11. MDTs do not need to be led by General Practitioners (GP), a false assumption circulated in society by the media and other platforms 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. 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 does not facilitate equitable access to care nor constitute leadership that ensures the person is at the centre of care.

12. 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 will be the only health professional available. Nurses and midwives are educated to provide leadership while working in multi-disciplinary teams (both locally, nationally and virtually) and many successful models of nurse and midwife led models of care exist and have been discussed in previous discussion papers and submissions. Leading care through and within MDTs is intrinsic to nursing and midwifery practice making them excellent examples of leaders in PHC. Nurse led PHC contributes to shorter length of hospital stay, decreased incidences of complications and reduced levels of anxiety and depression. It has also been found that nurse led PHC enhances a person's ability to self-manage and improves their quality of life.[1]
13. Respect for professional authority and autonomy is critical when implementing reforms. The health professions must continue to lead the governance, education, and practice of their own discipline: nurses and midwives must be managed by nurses and midwives. In some regions the development of maternity models of care is managed by health practitioners from a different profession which is unacceptable and not supported by the ANMF.

Workforce design, development, and planning

Options for reform developed in relation to workforce design, development and planning are:

- *National Skills and Capability Framework and Matrix*
- *Develop primary health care capability,*
- *Early career and ongoing professional development include multi-professional learning and practice.*

Q.2 To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?

__ To a great extent

__ Somewhat

☑ A little – more detail is required

__ Not at all

Please provide additional comments

National Skills and Capability Framework and Matrix

14. While employers have an obligation to understand the scope of practice (SoP) of those they employ, each profession must have a sound understanding of their own SoP. Nurses and midwives undertake initial pre-registration education to a generalist SoP, where consistency and quality is ensured through educational accreditation. Individual SoP will differ however, based on post graduate education, experience, skills, knowledge, and context of practice. No one person can understand the SoP of all other members of an MDT as these will differ, and it is the responsibility of each health professional to voice and work to their individual SoP, seeking appropriate education to expand their SoP when necessary. Similarly, teams

have a professional responsibility to learn about other health professionals working within the team. This is good work practice and demonstrates an environment of respect and is instrumental in building trust.

15. A National Skills and Capability Framework and Matrix may be useful only if carefully constructed using broad consultation across professions and where governance and decision-making powers remain with the relevant National Boards. The Nurses and Midwifery Board of Australia (NMBA) and the Australian Health Practitioner Regulation Agency (Ahpra) have successfully ensured the regulation of nurses and midwives since the implementation of the National Registration and Accreditation Scheme (NRAS) and the ANMF suggests it is appropriate for this to continue. For example, the NMBA/Ahpra already stores and disseminates information related to nursing and midwifery registration and endorsements.
16. The developers of a National Skills and Capability Framework must ensure it does not result in a task list that ignores the necessary critical thinking and decision making involved in the work of nurses and midwives. The National Nursing Workforce Strategy will be an important element in the way any Framework is structured, monitored, and administered.
17. A National Skills and Capability Framework must include the following to support SOP:
    - Foundational knowledge and practice
    - Communication and engagement
    - Access and equity
    - Ethical, safe and responsible practice
    - Accountability and responsibility
    - Personal and professional development
18. The ANMF does not support micro-credentialing and suggests skills and capabilities of regulated professions be tied to formal, nationally accredited qualifications offered by accredited higher education and vocational education and training (VET) providers to ensure credibility and validity of education programs. The terms *micro-credential* and *micro-credentialling* are poorly and inconsistently defined, with interpretation differing between professions, organisations, and workplaces. This situation results in a lack of consistency, standardisation, and transportability of these types of *certificates*. The lack of requirements for formal accreditation and monitoring of post registration courses, opens the door for unethical providers to take advantage of workers paying for expensive, substandard training. This potentially places the safety of the public and the worker at risk. It also presents a significant cost to governments and employers if they are required to outsource to private businesses.
19. While the ANMF does not support micro-credentialling, it does support nationally accredited Skill Sets that can be achieved post attainment of a formal qualification to augment or expand a person's skills and knowledge in their area of practice. This ensures credibility and

validity of education programs and assists employers and other health professionals to understand the skills and knowledge the professional has acquired via the Skill Set/s. Funding for Skill Sets would be welcomed to ensure providers of education and training are accountable for its delivery. Micro-credentials have the potential to cloud the skills and capabilities framework particularly if they are not nationally recognised or are only providing a 'tick and flick' approach to learning.

Develop primary health care capability.

20. Poor recognition and utilisation of PHC skills and knowledge across a range of health professional, leads to practice atrophy and the underservicing of communities. The ANMF supports the development of PHC capability in the healthcare workforce provided it is not reduced to a task list and it acknowledges the unique SoP of nurses or midwives.

21. Any Framework must have person centred and evidenced based practice at its core. It must not be driven by profit or the ability to provide a quick fix such as the example provided on page 33 of Issues Paper 2, which states,

> "From an employer perspective – the prescriptive nature of contracts is a key barrier in achieving full scope of practice. The current nature of them almost enforces siloing. In reality, we could employ a multiskilled workforce but instead sometimes have to employ specific nurse practitioners (i.e., mental health) due to the prescriptive nature of contracts resulting from how professions are defined under SoP legislation."

22. 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 the person seeking PHC can access the right health practitioner 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 health professionals or to meet the convenience of employers.

Early career and ongoing professional development include multi-professional learning and practice.

23. The ANMF supports early career development and multiprofessional learning for nurses and midwives who choose to work in PHC. Success will depend on building cultures of respect and trust through factors mentioned in Issues Paper 2 such as legislative and jurisdictional changes that facilitate nurses and midwives using and developing their skills and working unincumbered and to their full SoP.

24. The ANMF supports, in theory, the concept of strengthening interprofessional education (IPE) which is already included in the Australian Nursing and Midwifery Accreditation Council (ANMAC) education accreditation standards for nurses and midwives. However, the ANMF does not support making the accreditation standards (related to IPE) more prescriptive as it

risks overcrowding the curriculum and devaluing principles-based education. It can also work against innovation as it makes change slower and more difficult. Immersive pre-registration IPE is a wonderful idea, however, where there might be 2000 - 3000 students enrolled in a pre-registration nursing degree at one university, and making on campus immersive IPE compulsory or mandatory is logistically fraught and unrealistic.

25. Education and learning do not cease with graduation, rather it marks the beginning of a new part of the learning journey for health professionals, and this must be acknowledged in discussions about education. Pre-registration education is and should involve learning about the identity of the profession and how the individual incorporates that into their own experience.[2] IPE is one element of learning about the identity of nursing and midwifery and ideally happens once people enter the workplace (during clinical placement or as new registrants) as an immersive, clinically supervised and facilitated experience. Pre-registration IPE in the classroom/simulation setting is far more difficult to organise with large cohorts; they lack authenticity and by their very nature are limiting in their specificity. For pre-registration programs, courses taught across disciplines, such as anatomy and physiology already allow students to mix with those from other disciplines and learn incidentally in shared tutorial environments.
26. A significant issue the ANMF regularly hears from members is about the poor quality of clinical or professional experience placements in the PHC setting – often students are placed in private organisations (frequently general practices), with minimal support and poorly structured programs, sometimes, drawn up by office managers who are not clinicians and do not understand the significance of professional learning. Students are left feeling bored and put off by PHC when they graduate, choosing not to work in that setting. Additionally, they are exposed to nurses unable to work to their SoP because of legislation and organisational constraints. Placement quality must hold value and reflect the work of the PHC nurse or midwife. Nurses and midwives must be able to role model the full SoP to spark interest and enthusiasm in early career practitioners, for example, advanced practice nurses, nurse practitioners (NP) and endorsed midwives (EM) and those working in nurse and midwife led services such as the ACT Walk in Centres. Workplaces are remunerated when they accept students for placement and there should be an expectation that learning will be in consultation with the education provider and of a high standard.
27. Similarly attracting experienced nurses and midwives to the PHC sector is essential. This group has transferrable skills but still requires support to transition. Additionally, retaining experienced nurses already working in PHC is vital and allowing this group to work to their SoP as equal members in the MDT is a simple way of improving job satisfaction and retention. The 2023 APNA Workforce Survey shows that 31% of PHC nurses are only occasionally or rarely working to their full scope of practice. This same survey shows that nurses who cannot work to their full scope are more likely to leave PHC. Ensuring remuneration is fair and in line with public nursing awards is also a major factor in attracting and retaining nurses to the sector.
28. The ANMF supports the provision of high-quality professional experience placements in PHC and expects that nurses and midwives are supervised and facilitated by discipline specific

practitioners (nurses and midwives) to ensure learning focuses on the development of the professional identity of their chosen profession and how they work within an MDT.

29. The inclusion and support for clinical reflective supervision for all nurses and midwives working in PHC is an important part of professional development and ongoing learning.

Q. 3 How should the National Skills and Capability Framework and Matrix be implemented to ensure it is well-utilised?

30. A full and considered response regarding implementation of a proposed National Skills and Capability Framework and Matrix would require further detail to understand the skills and capabilities to be included, how they would be identified and how cross discipline qualifications would be validated and monitored. It remains unclear how the establishment of a Framework and Matrix will represent a health practitioner's skills and capabilities and how this will link to the individuals decision-making capability and reasoned clinical judgement, essential to nurses' and midwives' practice. It is also unclear what cross-professional governance structures are proposed to safeguard quality healthcare delivery and the protection of those it serves, especially vulnerable populations. Additionally, and as stated above, the ANMF does not support micro-credentialling as it is difficult to administer and monitor, may not be delivered by suitable or ethical education providers, and may limit workforce transportability resulting in additional out of pocket expenses for nurses and midwives if they are required to self-fund additional training.

31. Broad ranging consultation with those professions falling under NRAS would be required to identify and agree on any shared skills and capabilities. Multidisciplinary PHC Standards would be required to guide education. The Australian Commission on Safety and Quality in Health Care (ACSQHC) is well positioned to undertake this role based on existing clinical standards developed as part of the National Safety and Quality Health Service (NSQHS) Standards.

32. If a scheme was introduced to recognise cross discipline, post registration of shared skills qualifications, a national accreditation system would be required to ensure equivalence, provision and delivery of quality education and the meeting and incorporation of any PHC standards. It follows that the National Boards and existing accreditation bodies would be perfectly placed to expand their role and conduct accreditation of such courses. Additionally, Aphra has existing structures for overseeing the collection, verification and dissemination of information related to health professionals' entry to practice qualifications and it is suggested this could be expanded to include the acknowledgement of cross discipline education of shared skills qualifications.

33. Implementing any system of such magnitude and ensuring a shared vision and correct usage would require education and professional development for all stakeholders, including but not limited to, health practitioners, students, employers, educators, education providers, the public, the media, accreditation providers and so on. Given the numbers, geographical disbursement, and extensive contexts in which they work, nurses and midwives would be key players in the development and sharing of information regarding implementation and system changes.

34. The assessment of PHC skills and capabilities that could be performed by several healthcare disciplines should be restricted to those registered under the NRAS. Including professions that do not fall under the NRAS is problematic as they are not bound by the National Law designed to ensure protection of the public. Those professions do not have a regulated SoP (but roles) and should remain a separate group, acknowledging different roles and focus in the PHC context.

Q. 4 Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?

35. The health professions should lead the development of the relevant components of the framework and matrix to avoid skill and role erosion. Ahpra together with National Boards are the logical choice to ensure any such framework or matrix is applied correctly and effectively as it pertains to scope of practice. Additionally, Ahpra could register post registration qualifications against a regulated health practitioners name on the national register.

Legislation and regulation.

Evidence gathered to date has contributed to three proposed reform options related to legislation and regulation:

- *Risk-based approach to regulating scope of practice to complement protection of title approach.*
- *Independent, evidence-based assessment of innovation and change in health workforce models.*
- *Harmonised Drugs and Poisons regulation to support a dynamic health system.*

Q.5 To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?

__ To a great extent

__ Somewhat

☑ **A little – more information is needed**

__ Not at all

Please provide any additional comments.

Option 6 is supported as a priority as jurisdictional requirements frequently result in restrictions to SoP.

36. The ANMF supports a review of legislative and regulatory mechanisms to identify restrictions to scope of practice for nurses and midwives. As suggested in issues paper 2, restrictions often occur in opaque ways as seen with access to the Medical Benefits Scheme (MBS) by NPs and EMs through collaborative arrangements and restricted funding measures.

Thankfully change has commenced with the unpicking of collaborative arrangements but further reforms are needed to ensure the public has access to PHC practitioners that are affordable and available. Many communities, such as those in rural and remote areas, are already experiencing a shortage of GPs,[3] and despite large financial incentives, or levers such as the 19AB rule, recruitment and retention of GPs has not grown, resulting in poorer health outcomes and patient experiences, and reduced or delayed access to PHC with subsequent increased burden on other health services particularly emergency departments (ED).[4] The inability to see a GP also results in reduced access to medical specialists, delayed diagnosis and treatment because GPs are the only health practitioner who can issue a referral. Reforms to change these and other constraints, that allow nurses and midwives to refer people for diagnostics and onto specialist medical and allied health services will help to improve access to PHC, earlier diagnosis and treatment and improvement of health outcomes.

37. There are concerns in relation to options 4 and 5 that require further information to provide a fuller understanding and evaluation of possible unintended consequences. The SoP review must not erode existing scopes of practice under the guise of reform and any reform must ensure all professions are treated with equal respect, given a voice and are heard.

38. Similarly, 'who is defining *risk* and undertaking the risk assessment?' is an important question in relation to this reform. It should also be noted that these assessments are complex and will be somewhat determined by the context of practice.

39. While implementation of cross discipline skills offers the potential to facilitate nurses and midwives working to their full SoP and improving access to PHC by the public, there exists the potential to diminish the discipline's SoP if other professions are authorised to perform work for which nurses and midwives are specifically educated and prepared. To enable change and adoption of new ways of working, information about how shared areas of practice is identified must be investigated by and in consultation with all regulated health disciplines. Long term solutions must be the primary strategy and investment, rather than expedient measures which ultimately only provide band aid solutions.

40. As the Issues Paper 2 notes (page 50), the current legislative and regulatory mechanisms in Australia have been effective in protecting public safety. With protected titles, the community can understand what each health practitioners' role is and this helps to establish confidence within the community. Protected titles must be maintained and where a shared skills framework is employed (such as that for vaccination) wide ranging education and communication of the public must occur through media and other avenues to avoid leading to public confusion and disengagement.

Q.6 To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?

__ To a great extent

__Somewhat

☑Probably somewhere in between

__A little

__ Not at all

Please provide any additional comments.

41. More detail is needed to make a fully informed response to this question; however protection of titles is paramount for numerous reasons, some of those already stated in earlier comments.

42. Governance of practice, policy and education for nurses and midwives must be retained by nurses and midwives. Oversight by another profession such as medicine is unacceptable and would signal a step back in time. The ability of professions to remain self-governing and independent and autonomous in their practice is essential.

43. As outlined above, the ANMF does not support micro-credentialling but specific standards for post graduate courses linking shared areas of practice (for example, vaccination) could be used to guide curriculum. Such an approach should lie with the higher education/VET sectors and attached to an accredited qualification to ensure validity and credibility. Any cross discipline PHC practice standards should be developed by the ACSQHC.

44. Enabling the Health Ministers' Meeting (HMM) to give policy direction to Ahpra and the National Boards and policy directions to educational accreditation authorities, risks politicising health education. This leaves the education system open to manipulation based on political agendas. The focus must instead be on ensuring the intent and outcomes remain about educating health professionals to ensure the safety of the public. The safety of the public must continue to be paramount and to do this accreditation authorities must remain as independent.

Q. 7 What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

45. As flagged in Issues paper 2, the complexity involved in changing legislation or jurisdictional issues must be considered and the consequences of change explored. For example, a move from State to Federal legislation, could add complexity to decision making and result in inertia and stagnation. Any changes must be achievable and lead to innovation and improvement. Establishing effective communication channels is essential.

Funding and payment policy

Two options for reform have been developed relating to the theme of funding and payment policy:

- *Funding and payment models incentivise multidisciplinary care teams working to full scope of practice.*
- *Direct referral pathways supported by technology.*

Q. 8 To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

__ To a great extent

__ Somewhat

☑ **Somewhere in the middle**

__ A little

__ Not at all

Please provide any additional comments.

46. Nurses and midwives are by far the largest and most widely dispersed PHC health professionals in Australia.[5] To ensure equity, funding incentives including the Workforce Incentive Program (WIP) and Practice Incentive Program (PIP) payments should be directly available for nurses and midwives and not dependent on oversight, presence or collaborative arrangements with GPs. To ensure equity and appropriate delivery of PHC, such funding should be nurse and midwife specific, not combined with allied health professional funding, which should be available separately. This makes sense, as it acknowledges that nurses and midwives have very different roles and scopes of practice to those of allied health professionals. It must also be acknowledged that PHC happens in numerous contexts outside general practice and is provided by health practitioners other than GPs.

47. The focus on providing GP incentives that attempt to channel people into general practices to access PHC is unrealistic, simplistic and tokenistic and ignores questions about why people do not visit general practices and GPs for PHC. It also perpetuates problems with PHC coverage and access as it ties funding solely to general practices and GPs, so people without feasible access to these services miss out. If PHC is to be person centred and not provider centred, vulnerable and diverse groups must be considered and supported to receive PHC in places that they consider safe and accessible. Nurses are already providing outreach care to vulnerable populations through a variety of clinics and models of care,[6,7] for example, clinics in homeless shelters.[8,9,10] In many instances, due to trauma, lack of trust, past experiences, stigma and cost, people do not feel safe or able to access PHC through general practices.[11,12] Funding beyond general practices and redirecting incentive payments for GP services into salaried funding will have flow on effects and cost savings, including early intervention for vulnerable populations, chronic disease management and a reduction in emergency department presentations and hospital admissions.

48. While a growing body of research supports the efficacy of nurse-led care models, substantial policy and financial constraints impede primary healthcare (PHC) nurses from practicing to the full extent of their qualifications. To unlock their potential and revolutionize healthcare delivery and expand access to services, these barriers necessitate urgent attention.[13]

49. At some point, Governments must accept that positive and negative levers designed to attract GPs to rural areas have been expensive and largely unsuccessful in addressing workforce shortages in rural and remote communities or in improving access to affordable PHC.[14,15] It is time to look toward the addition of other regulated health practitioners and the use of funding for other models of care that are not based on unsustainable and ineffective incentivising of private businesses. Many models of person centred PHC led by

nurses and midwives already exist to support the health needs of rural and remote communities.[16]

50. The suggested approaches in Issues paper 2 may be successful if members of the MDT can work to their scope of practice and understand the scopes of practice and role descriptions of other members of their team. MDTs should not be based on traditional hierarchical models but rather an environment of mutual respect that is funded so **all** health practitioners can deliver appropriate care collaboratively without being controlled by other disciplines.

51. With the increasing availability of diagnostic assistance through AI and sharing of test results using secure internet platforms, communities can be less reliant on the physical presence of a medical specialist. Nurses and midwives are skilled and educated in assessment and are used to conducting case conferences, using video links to speak with patients, families, specialists, and GPs from a variety of locations, for example from the clinic or a person's home (virtual care). In many instances specialists only need travel to a location for short periods of time (days per month) to see lists of more complex cases who have been prioritised in consultation with the MDT. To be most effective however, funding must directly support alternative ways of working and the practitioners who are providing the service.

52. Reconsideration of the models of care used to deliver PHC is needed especially in areas of workforce shortages, including the need for legislative and cultural changes that allow nurses and midwives to work to their scope of practice and as equal primary healthcare providers and members of the MDT. The ANMF supports changes that allow NPs and EMs to refer and order diagnostics, reducing the need for GPs to be present and expanding and expediating access to specialist services. It must be acknowledged that nurse and midwife led models of care along with paramedic services provide quality PHC to communities that have no, or limited access to a GP. Further, such services must be funded as an ongoing solution rather than the current view that these are stop gap measures.

53. The introduction of MDTs and the use of technology to be used as tools to enhance face to face and remote services in rural and remote areas must be supported through direct funding and legislative change. Whilst technology should never replace face to face healthcare, it can assist in screening, diagnosis, and communication. It offers the MDT who are physically present, the ability to access specialist (including NPs) and GP services (if needed) remotely via televisual communication, allowing members of the MDT to be with the person seeking specialist services while speaking with a specialist practitioner virtually. This already occurs in areas across Australia. Technology requires funding and commitment for ongoing support and education, for all members of the MDT and inclusion in pre-registration curriculums. It also requires ongoing funding for infrastructure, maintenance and other on costs for equipment and web-based services.

54. Redirection of incentive payments could help to fund different models of person-centred care and support block and salaried positions.

Q. 9 What other implementation options should be considered to progress the policy intent of these options for reform?

55. The depth and breadth of any policy reform requires significant planning, staging and

periodic reviewing, to ensure that change occurs through a systematic approach that effects improvements in both health service delivery and health care outcomes.

56. As highlighted in Issues Paper 2, implementation of the proposed reforms must be supported and enabled by a range of cultural, leadership, and clinical governance mechanisms. Significant engagement between stakeholders will be necessary to reach consensus between all decision-makers throughout the process. Likewise, building in a strong framework of evaluation and research components to gather, synthesise, and report on relevant evidence will be critical to achieving the level and depth of oversight required to clearly monitor the reforms. Effective implementation of healthcare reforms necessitates a robust, evidence-informed framework.

57. Implementation science is a powerful tool to guide the introduction of a comprehensive suite of reforms that empower healthcare professionals to practice to the full extent of their scopes of practice. This approach emphasises a nuanced understanding of the specific contexts where healthcare professionals work, encompassing the healthcare system, prevailing clinic culture, and the diverse skillsets and scopes of practice of healthcare personnel. Such contextual analysis allows for the targeted identification of key barriers that impede professionals from working to their full potential. These barriers can be broadly categorized as policy-related (for example, limitations on the scope of practice for nurses), financial (for example, lack of reimbursement mechanisms for nurse-led services), or cultural (for example, resistance from other healthcare professionals or groups).

58. Implementation science offers a valuable framework for selecting the most appropriate strategies based on the existing research evidence. Frameworks like the Expert Recommendations for Implementing Change (ERIC) provide a menu of evidence-based strategies (for example, educational workshops, financial incentives, audit and feedback) tailored to address different types of barriers. Importantly, implementation science rejects a one-size-fits-all approach by advocating for continuous evaluation of the implemented reforms. This iterative process allows for the ongoing refinement of strategies to ensure optimal effectiveness.

59. To address policy barriers, implementation science can inform targeted advocacy efforts or pilot programs that demonstrably illustrate the safety and efficacy of nurse- and midwife-led (or allied health-led) models. Similarly, for financial barriers, implementation science can guide cost-effectiveness studies of expanded nurse roles, providing policymakers with data to support potential reimbursement changes. Finally, to address cultural barriers, implementation science can inform the development of educational workshops or mentorship programs that foster collaboration between nurses, midwives, and other healthcare professionals.

Q. 10 What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of these policy options?

60. The need for effective leadership and governance is frequently mentioned as critical to the options proposed throughout Issues Paper 2, however the Paper remains vague as to what this would entail or how it could be collectively achieved without biasing one profession.

61. The establishment of a transparent evaluation processes will be critical to assess the extent to which reforms are implemented successfully and demonstrate the way funding is distributed, used, and links to outcomes. The importance of planned evaluation, transparent processes, and accountability in light of sweeping healthcare reform cannot be overstated.

Last Word

Q. 11 Are there additional reform options which have not been considered that could progress the intent of this Review?

62. The nature of such broad reforms will require change management processes that are agile and responsive to challenges and opportunities as they present. A structured approach as to how these can be identified and managed would benefit the reform's agenda. Planned and targeted research will be needed as will the generation and collection of data to help inform and monitor change and quality improvement through evidence.

Conclusion

63. The ANMF welcomes the opportunity to respond to the Scope of Practice Issues Paper 2 and supports the intent of the review. As indicated throughout this response, additional information may help to provide clarity and more informed responses in the future.

64. Credentialling and Micro-credentialling is not supported by the ANMF for the reasons outlined earlier.

65. The ANMF supports,

- Nurse and midwife led models of care.
- Ongoing discussion regarding the identification of professional shared clinical skills and the development of shared PHC standards to guide practice across disciplines.
- The use of existing agencies for educational accreditation of post graduate qualifications, acknowledgment and publishing of qualifications and development of standards, to avoid the duplication of services and reduce confusion by the healthcare industry or the public.
- The retention of legislated governance structures and protected titles by each of the regulated professions.
- The use of IPE as an immersive professional education placement experience or post-registration component of transitioning to practice.
- The redirection of incentive funding for nurses and midwives, that is not dependant on collaborative relationships with GPs or general practices.
- The removal of gatekeeper practices associated with funding and access to the MBS.

- The removal of jurisdictional barriers.
- Acknowledging that PHC happens in many settings outside general practice for example those already offered through nurse and midwife- led services particularly those supporting rural communities.

66. The SoP review presents a once in a generation opportunity to improve access to and affordability of PHC while continuing to guarantee the safety of the public. Focus must be on the person at the centre of care and looking to the evidence to help guide decisions rather than allowing other agendas to control the PHC system. It is essential to realise the full value of every health profession in helping to deliver the right care, at the right time and in the right place.

[1] Lei YY, Ya SRT, Zheng YR, Cui XS. Effectiveness of nurse-led multidisciplinary interventions in primary health care: A systematic review and meta-analysis. International Journal of Nursing Practice. 2023;29(6):e13133.

[2] Douglas J. Early career registered nurses: How and why do they stay? Exploring their disorienting dilemmas. University of Wollongong: University of Wollongong; 2019.

[3]Australian Medical Association (2022). "The general practitioner workforce: why the neglect must end." Australian Medical Association: Barton, ACT.

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