



## Practice nursing in Australia

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### Executive summary

This research paper explores aspects of the recent development of practice nursing in Australia, particularly those relating to government initiatives currently in place. The paper also discusses some of barriers which may inhibit the further development of practice nursing, and makes some comment on how these could be addressed in the future.

Changing health needs and increased patient expectations about health care delivery have led to recognition by the nursing and medical professions and by government of the potential to use the services of nurses more effectively to enhance the delivery of primary care services.

Health care in the future will involve greater health promotion, chronic disease monitoring and care of older patients. This situation has led to recognition that general practice needs to evolve to cope with an increasing complexity in care. This will involve making more astute use of existing resources and cultivating innovative use of other health professionals, particularly practice nurses.

Early development of a practice nurse specialisation has required a number of actions:

- promotion of the specialty to nurses, general practitioners and patients;
- providing incentives to nurses to embrace the specialty as a legitimate nursing alternative, to general practitioners so that they recognise the benefits to their practice and to patients so they see positive health outcomes; and
- education and support for nurses to undertake practice nursing work.

These tasks have required the cooperation of the nursing and medical professions. They have also involved government programs and support.

Barriers remain for the further development of practice nursing. These barriers at present limit the extent to which practice nursing is able to maximise the resources of general practice into the future and to contribute to better and safer patient care.

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## Introduction

Health workforce shortages have for some time caused concern in Australia. A number of studies have emphasised an underlying need 'to develop a more sustainable and responsive health workforce, while maintaining a commitment to high quality and safe health outcomes'.<sup>1</sup>

The numbers of health professionals have increased. However, demographic changes, such as the ageing of the population and of the various health workforces, have combined with increasing demands for health services to escalate the problems associated with shortages.

In attempting to address health workforce shortages generally and medical workforce shortages in particular, federal governments have introduced a number of initiatives including regulatory restrictions and incentive payments.<sup>2</sup> Some of these have involved programs that encourage development of the practice nurse specialisation.

The term 'practice nurse' is generally applied to qualified nurses who are employed by medical general practices.

General practice nursing has been regarded as a nursing specialty in the United Kingdom since 1966 and in New Zealand since 1970. Practice nursing, however, is a relatively new area of nursing specialisation in Australia.

Practice nursing in Australia traditionally has been a means through which nurses have been able to accommodate family commitments by engaging in part time employment which has not involved shift work. Working in general practice therefore has been seen as an expediency measure, rather than a career in itself. Consequently, there has been little acknowledgement of the special skills nurses need to work in general practice and almost no formal education to prepare and support nurses in the practice nursing role in Australia. For some time there was also speculation in Australia that practice nursing was detrimental to nurses' careers as it was thought that professional competency could possibly be diminished as a result of working in general practice.

In recent times, these views of practice nursing have altered. One reason for this is that a combination of factors, such as shortages in the general practitioner workforce, rising patient expectations and an increase in the numbers of elderly and chronic disease patients have

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1. Productivity Commission, *Australia's health workforce*, December 2005, <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf> accessed 14 March 2007.
  2. Regulations were introduced in 1996 under the *Health Insurance Act 1973* which generally restrict access to Medicare for services provided to those medical practitioners with post graduate qualifications. Incentive schemes include the More Doctors for Outer Metropolitan Areas Measure.

combined to put increasing pressures on the delivery of effective primary care. In addressing these pressures, innovative solutions for the more efficient delivery of primary care have been sought. One of these solutions recognises the potential of nurses working in general practice to improve and enhance the delivery of services in this environment.

British research in the late 1990s suggested that 25 to 70 per cent of the work undertaken by doctors could be undertaken by nurses,<sup>3</sup> particularly in the areas of health promotion and routine management of chronic diseases such as asthma, diabetes and heart disease.

Giving nurses this extended role, according to British analysis, can deliver many positive outcomes. Overall, it can enhance the quality of service general practices can provide to patients. It can also allow for safe substitution of services previously provided by doctors alone, thus reducing the demand for doctors. In addition, it is beneficial in terms of cost efficiency, as nursing services cost less than medical services.<sup>4</sup>

Australian studies have concurred that there is considerable potential to use practice nursing to improve the delivery of services in general practice. However, it has been argued that many issues need to be dealt with in developing practice nursing to its optimum potential.

Some of these are being addressed. For example, in moving towards the acceptance of practice nursing as a specialty in its own right, a documented role description of the specialisation has been developed in conjunction with competency standards for the specialty. Other requirements remain in the developmental phase. These include the provision of formal education for practice nursing and the establishment of professional and organisational support for practice nurses.<sup>5</sup>

There has been considerable cooperation between government and the medical and nursing professions in working towards the development of the practice nursing specialty. There is more to be done, however, to ensure practice nursing evolves to make greater contributions in the general practice environment.

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3. M. Richardson, 'Identifying, evaluating and implementing cost-effective skill mix', *Journal of Nurse Management* 5, 1999, pp.265-270. Quoted in M. Laurent, D. Reeves, R. Hermens, J. Braspenning, R. Grol and B. Sibbald, 'Substitution of doctors by nurses in primary care', *Cochrane Database of Systemic Reviews*, 2004, Issue 4  
<http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001271/frame.html>  
accessed 27 March 2007.
  4. *ibid.*
  5. I. Watts, E. Foley, R. Hutchinson, T. Pascoe, L. Whitecross and T. Snowdon, *General practice nursing in Australia*, Royal Australian College of General Practitioners and Royal College of Nursing Australia, May 2004  
[http://www.rcna.org.au/content/general\\_practice\\_nursing\\_in\\_australia\\_main\\_report.pdf](http://www.rcna.org.au/content/general_practice_nursing_in_australia_main_report.pdf)  
accessed 20 March 2007.

## Background – practice nursing overseas

### United Kingdom

Practice nurses are now considered integral to the health system in the United Kingdom. However, the specialty first developed in an ad hoc manner in the 1960s as a reaction to perceptions that community nursing was not adequately responding to patients' needs.<sup>6</sup>

It was not until National Health Service (NHS) Reforms were introduced in the 1980s that the specialty developed substantially, with the numbers of practice nurses rising from an estimated 1900 in 1984 to over 7,500 by 1990.<sup>7</sup> Introduction of the 1990 NHS General Practice Contract and subsequent renegotiations of the Contract have also contributed to the development of practice nursing and a rise in practice nursing numbers.<sup>8</sup> In 2003, there were approximately 25,000 practice nurses in the United Kingdom.<sup>9</sup>

Jane Broadbent argues that the focus of the General Practice Contract on health promotion 'provided a new role for practice nurses who were employed to undertake tasks rejected by

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6. K. Aitkin and N. Lunt, *Nursing in practice: The role of the practice nurse in primary health care*, Social Policy Research Unit, University of York, 1995. Cited by E. Halcomb, P. Davidson, J. Daly, R. Griffiths, J. Yallop and G. Tofler, 'Nursing in Australian general practice; directions and perspectives', *Australian Health Review*, Vol 29, No 2, May 2005, p.157.

7. K. Aitkin and N. Lunt, 'A census of direction', *Nursing Times*, 42, pp. 38-41. Quoted by J. Broadbent, 'Practice nurses and the effects of the new general practitioner contract in the British NHS: the advent of a professional project?' *Soc. Sci. Med.*, Vol 47, No 4, pp. 497–506.

8. In 1948, British general practitioners agreed to work under a capitation system. However, problems in relation to earnings under this system had arisen by the 1960s when doctors lobbied for changes in pay and conditions under a general practice contract system. See <http://www.redbook.i12.com/rb/Docs/rb722.htm>.

In 1990 a change to this system imposed different treatment on general practitioners. The British Government had always dealt with general practitioners as independent contractors, in 1990 however, general practitioners were treated almost as business entrepreneurs. See <http://www.bmj.com/cgi/content/full/314/7084/895>.

According to the Royal College of Nursing, the 1990 general practice contract introduced much more closely specified terms and conditions and led to increases in practice nurse numbers as general practitioners struggled to reduce costs and meet more stringent contractual requirements. <http://www.rcn.org.uk/news/congress2003/display.php?ID=423&N=08> accessed 14 June 2007.

9. Royal College of General Practitioners (RCGP), *Practice nurses*, August 2004, [http://www.rcgp.org.uk/pdf/ISS\\_INFO\\_19\\_AUG%2004.pdf](http://www.rcgp.org.uk/pdf/ISS_INFO_19_AUG%2004.pdf) accessed 28 March 2007.

[general practitioners]' and that practice nurses in the United Kingdom have embraced this role with enthusiasm.<sup>10</sup>

Changes to the NHS in 2004 revealed that a number of issues, such as pay and working conditions for practice nurses, still need to be addressed, despite the fact that the speciality is well-established in the British system.<sup>11</sup> Nevertheless, the various NHS changes have created further opportunities for practice nursing to evolve. For example, practice nurses are able to become partners in general practices, thereby taking on a more strategic role in the delivery of primary care. They are also able to become sub providers of services, such as sexual health or immunisation services.<sup>12</sup>

One of the recent changes to the NHS, however, the extension of nurse prescribing rights, has met with opposition from the British medical profession. Prescribing rights for nurses, which were introduced in 2002 for minor injuries, had previously been subject to criticism but the British Medical Association (BMA) has contested an extension granted in 2006 of the right to prescribe.<sup>13</sup> The BMA argued it was not opposed to limited prescribing rights for nurses, as it saw merit for patient outcomes in these rights, but it believed 'only doctors have the necessary diagnostic and prescribing training that justifies access to the full range of medicines for all conditions'.<sup>14</sup>

Currently, of the over 6,500 nurses who are registered to the higher level of prescribing in the United Kingdom under the extended prescribing rights initiative, most are not engaged in practice nursing. Higher level prescribing is mainly used by advanced nurse practitioners, who use this prescribing to augment the care they provide in nurse-led clinics or in outreach work in palliative care.<sup>15</sup>

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10. Aitkin and Lunt in Broadbent, op. cit.

11. For example, it was noted at the Royal Nursing College Congress in 2003 that many practice nurses were denied annual NHS pay increases, increments and discretionary enhancements. They were unable to contribute to the NHS pension scheme and were not eligible for cost of living allowances. Many were also subject to the variable employment policies adopted by their general practitioner employers.  
<http://www.rcn.org.uk/news/congress2003/display.php?ID=423&N=08> accessed 22 June 2007.

12. RCGP, op. cit.

13. Under this extension, experienced nurses and pharmacists who undergo specific training are able to prescribe a broader range of drugs. Prescribing of controlled drugs, such as morphine, continues to be limited.

14. L. Barclay, 'UK expands prescribing powers for nurses, pharmacists', *Medscape Today*, <http://www.medscape.com/viewarticle/517497> accessed 28 March 2007.

15. S. Dolan, *Nurse prescribing in the United Kingdom*, Royal Marsden NHS Foundation Trust, <http://www.cancerworld.org/CancerWorld/getStaticModFile.aspx?id=1442> accessed 28 March 2007.

## New Zealand

In 1970, the New Zealand government introduced a practice nurse subsidy to encourage general practices to employ nurses. According to one source, this was not initially successful in that it did not automatically result in practice nurses assuming greater clinical workloads.<sup>16</sup> However, since 1983, when the government introduced a funding requirement that nurses undertake specific clinical duties, practice nursing as a discipline has developed significantly. As in the United Kingdom, practice nurses are an integral component of the primary health care system, with New Zealand general practices employing on average 2.4 practice nurses.<sup>17</sup>

While the New Zealand Primary Health Care (PHC) Strategy acknowledges that nurses are 'crucial' to its successful implementation, in 1998 a Ministerial Taskforce on Nursing acknowledged that the value of this form of nursing was still to be realised fully. The Taskforce noted also that employment status and payment structures, as well as a lack of consistent standards and attitudinal factors, created barriers to further expansion of the specialty in New Zealand.<sup>18</sup>

Since that time, a strategic professional development framework has been put in place and this is supported by education and accreditation programs.<sup>19</sup> Funding remains contentious in New Zealand, however, as nursing services are constrained by population health funding that is linked to general practitioners. It is argued that general practitioners in turn are reluctant to relinquish control over general practice. As one observer notes, it has been difficult for many to separate employee/employer status from professional status. But supporters of practice nursing insist this separation 'must be facilitated to allow the growth of clinical autonomy of [practice nurses] as they attempt to expand their current nursing services and meet the challenges put forward by the PHC Strategy'.<sup>20</sup>

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16. B. Docherty, *Nursing in general practice: A New Zealand perspective*, Caxton Press, Christchurch, 1996.
  17. 2005 Royal New Zealand College of General Practitioners Membership Survey, General Practice in New Zealand, *Future workforce intentions, team work and remuneration*, March 2006, <http://www.rnzcgp.org.nz/news/docs/RNZCGP%20Report%20FINAL.pdf> accessed 28 March 2007.
  18. Ministry of Health, *Report of the Ministerial Taskforce on Nursing*, Wellington, 1998. Quoted by E. McKinlay, 'New Zealand practice nursing in the third millennium: Key issues in 2006', *New Zealand Family Physician*, vol. 33, no. 3, June 2006.
  19. See New Zealand College of Practice Nurses, Strategic Plan 2002–2005, [http://www.nzno.org.nz/Site/Sections/Colleges/Practice\\_Nurses/Strategicplan.aspxand](http://www.nzno.org.nz/Site/Sections/Colleges/Practice_Nurses/Strategicplan.aspxand) accessed 20 March 2007.
  20. R. Minto, 'The future of practice nursing', *New Zealand Family Physician*, Volume 33, Number 3, June 2006, [http://www.rnzcgp.org.nz/news/nzfp/June2006/Minto\\_June\\_06.pdf](http://www.rnzcgp.org.nz/news/nzfp/June2006/Minto_June_06.pdf) accessed 28 March 2007.

One critic of the current situation is particularly concerned that the issue of power and professional practice autonomy for practice nurses has not been addressed 'in a constructive and mutually respectful way'.<sup>21</sup> This critic calls for a move away from what she sees as an hierarchical health model to a shared governance model. She considers that this will require 'recognising equity of professional roles, ownership of responsibilities by all staff, accountability for one's practice and commitment to a partnership philosophy'.<sup>22</sup> She sees this as resulting in positive outcomes – improved job satisfaction, higher organisational effectiveness and better patient satisfaction and health outcomes.<sup>23</sup>

In opposition to this view, another observer of practice nursing in New Zealand has concluded that despite the existence of the types of barriers noted above, it appears that the practice nursing model adopted has made a positive contribution to the nation's health system. This is because general practitioners and practice nurses actually work together rather than alongside each other to deliver 'new and effective ways of providing care'.<sup>24</sup>

## Practice nurses in Australia

### Definition and work practices

The Australian Practice Nurse Association of Australia defines its members as degree qualified, registered nurses or certificate qualified, enrolled nurses<sup>25</sup> who are employed by, or whose services are otherwise retained by general practice.

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21. *ibid.*

22. *ibid.*

23. *ibid.*

24. B. Sibthorpe, 'A System–Eye View from an Australian Perspective: Reflections on the IPA Council (IPAC) of New Zealand Conference', Rotorua, 14–15 May 2004, Australian Primary Health Care Research Institute, [http://www.anu.edu.au/aphcri/Publications/Reflections%20on%20the%20IPAC%20conference\\_final.pdf](http://www.anu.edu.au/aphcri/Publications/Reflections%20on%20the%20IPAC%20conference_final.pdf) accessed 20 March 2007.

25. See <http://www.aihw.gov.au/labourforce/nurses.cfm> and <http://www.apna.asn.au/displaycommon.cfm?an=2> accessed 29 March 2007.



### **Nursing categories**

Nurses are classified into two broad categories:

- registered nurses (who usually have a degree), and
- enrolled nurses (who usually hold a certificate or advanced diploma).

Registered nurses make up the majority of all nurses.

Although the level of expertise varies within these groups, in general, registered nurses perform more complex medical procedures and hold more responsibility than enrolled nurses. For instance, in most jurisdictions only registered nurses have the authority otherwise retained by general practice to administer medications.

There are also other differences between registered and enrolled nurses. In general, registered nurses are more likely to be employed in critical or intensive care and less likely in geriatrics/gerontology; more likely to be employed in acute care hospitals and less likely in nursing homes; less likely to be working part-time; and more likely to work in capital cities, than enrolled nurses.<sup>26</sup>

In 2004, a study by the Royal Australian College of General Practitioners (RACGP) and the Royal College of Nursing Australia (RCNA)<sup>27</sup> found that general practice nurses in Australia were usually registered nurses who worked part time in medium to large general practices. They often worked with other nurses, who could be either enrolled or registered nurses. They had usually worked in general practices for less than five years and importantly, they had little general practice specific education.

The RACGP/RCNA study categorised the work practice nurses undertook into four different, but overlapping, responsibilities:

- clinical care, which involved clinical based procedures and activities
- clinical organisation, which involved activities that required management, coordination and administration
- practice administration, which required providing administrative support to general practice as a business enterprise and

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26. See the website <http://www.apna.asn.au/displaycommon.cfm?an=2> accessed 29 March 2007.

27. Watts, et al., op. cit.

- integration, which required development of effective communication channels within general practices and between practices and other organisations and individuals.<sup>28</sup>

Patient demographics of individual general practices influence the roles practice nurses play within those practices. The role for a practice nurse in an area with a large proportion of young families, for example, is most likely to focus on immunisation and child health issues.

Government initiatives and primary care funding also influence the roles practice nurses play in the general practice environment.<sup>29</sup>

## Practice nurse numbers

As the table below from the Australian Institute of Health and Welfare (AIHW) shows, in 2003, there were 236,645 nurses employed in nursing in Australia. Of these, 189,071 were registered nurses and 47,574 were enrolled nurses.

### Persons employed in nursing in Australia - 2003

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Enrolled	12,625	17,446	6,245	4,183	5,180	929	631	335	47,574
Registered	61,855	49,089	33,218	16,800	16,703	5,425	3,189	2,792	189,071
<b>All nurses</b>	<b>74,480</b>	<b>66,534</b>	<b>39,463</b>	<b>20,984</b>	<b>21,883</b>	<b>6,354</b>	<b>3,821</b>	<b>3,126</b>	<b>236,645</b>
Rate (per 100,000 population)	1,115	1,355	1,038	1,076	1,434	1,331	1,182	1,575	1,191

Source: AIHW<sup>30</sup>

The AIHW has not published statistics on the number of nurses working in general practice. However, it appears that practice nurses do not make up a large percentage of nurses. A National Practice Nurse Workforce Survey Report estimated that in December 2005, approximately 5,000 practice nurses were employed in general practice. Eighty two per cent of these were registered nurses. Consistent with the nursing profession as a whole, practice nurses were an ageing workforce with 73 per cent over the age of 40 years.<sup>31</sup>

28. *General practice nursing in Australia*, op.cit

29. Royal College of Nursing Australia, *Nursing in general practice*, <http://www.rcna.org.au/content/screenrez.pdf> accessed 29 March 2007.

30. Australian Institute of Health and Welfare, *Overview of Nursing*, <http://www.aihw.gov.au/labourforce/nurses.cfm> accessed 6 March 2007.

31. Australian Divisions of General Practice, *National practice nurse workforce survey report*, April 2006, [http://www.adgp.com.au/client\\_images/44225.pdf](http://www.adgp.com.au/client_images/44225.pdf) accessed 8 March 2007.

## Acceptance by the medical profession

It appears that practice nurses have been accepted unequivocally by the Australia medical profession as a viable tool to augment the services of general practitioners. It can be argued that one reason for this acceptance is that there is no current suggestion that the employment of practice nurses will diminish the role general practitioners play in the delivery of primary care services. In contrast, the medical profession sees nurse practitioners (see description below) as a threat; a profession that could, at least partially, replace general practitioners.

### **Nurse Practitioners:**

#### **United States**

In the United States, nurse practitioners are defined as registered nurses with advanced academic and clinical experience. Nurse practitioners are registered in America to provide some care previously offered only by general practitioners and in most American states they are able to prescribe medications, although the actual scope of their practices can vary in compliance with state regulations.

Nurse practitioners work mainly in the areas of health maintenance, disease prevention, counselling and patient education in primary care settings, but they are also employed in a number of specialties, including neonatology, nurse-midwifery, paediatrics, school health, family and adult health, women's health, mental health, home care, geriatrics and acute care.<sup>32</sup>

Historically, nurse practitioners have filled the gap in health care delivery to the underserved segment of the American population. This includes those living in rural areas, on American Indian reservations and in poorer inner city areas. More recently, nurse practitioners may be found in acute care settings, health maintenance organisations and private practices.

#### **United Kingdom**

Nurse Practitioners in the United Kingdom are required to be registered nurses who have undertaken a specific course to acquire skills necessary to be accepted to practice. The Royal College of Nursing notes that nurse practitioners offer a complementary source of care to that offered by medical practitioners. Nurse practitioners also provide care 'to people who previously had limited access to health care services – for example, [by] working in remote rural areas...working with homeless people, asylum seekers and refugees, and sex workers'.<sup>33</sup>

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32. See description of nurse practitioners at <http://www.nurse.org/acnp/facts/whatis.shtml> accessed 16 March 2007.

33. See Royal College of Nursing, 'Nurse practitioners', at <http://www.rcn.org.uk/publications/pdf/NursePractitioners.pdf> accessed 16 March 2007.

### **Australia**

The New South Wales Department of Health describes nurse practitioners as nurses who provide expert nursing care by working with a high level of clinical decision making expertise based on extensive skills and knowledge. Generally in Australia, nurse practitioners are considered competent to:

- Diagnose and treat acute health problems, such as infections and minor injuries
- diagnose, treat and monitor chronic diseases such as diabetes and hypertension
- order, perform and interpret specific diagnostic tests
- possess, supply and prescribe specific formulary medications and
- refer to, and accept referrals from other health professionals as necessary.<sup>34</sup>

This attitude partially explains a continuing interest shown by the medical profession in the development of practice nursing in Australia. Clearly, if doctors are pivotal in setting standards for education and role model guidelines, it is unlikely that controversial debates about the scope of nursing practice, such as those concerning prescribing rights which recently surfaced in the United Kingdom, will arise. There is no denying the genuine support for practice nurses amongst the medical profession in Australia, but it should be acknowledged that this support is counter to its opposition to alternative practitioners, particularly nurse practitioners.

In the words of the Australian Medical Association Council of General Practice (AMACGP):

Accrediting nurses to go out and independently diagnose, prescribe and refer patients is the wrong way to go. Independent nurse practitioners cannot and should not replace the expertise and care provided by [general practitioners]. It would be consigning patients in areas of workforce need to inferior health care. The State Governments endorsing independent nurse practitioners are looking for an easy, and vastly inferior, solution – which is also an irresponsible and dangerous path to follow.<sup>35</sup>

Practice nurses on the other hand, fit neatly into existing cultural perceptions and practices. While the AMACGP may see nurse practitioners as a threat, practice nurses are perceived as an integral part of the general practice team. They

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34. See pamphlet at [http://www.health.nsw.gov.au/pubs/2005/pdf/nursemidwife\\_pracs.pdf](http://www.health.nsw.gov.au/pubs/2005/pdf/nursemidwife_pracs.pdf) accessed 16 March 2007.

35. Australian Medical Association, Council of General Practice, *GP Network News*, 8 April 2005, <http://www.ama.com.au/web.nsf/doc/WEEN-6B89ZV> accessed 16 March 2007.

complement and assist the work of the [general practitioner], not ... become a substitute for general practitioners. General practice nurses help doctors see more patients and spend more time with patients who have chronic or complex illnesses – but they do so as part of the general practice team under the supervision of a [general practitioner].<sup>36</sup>

Regardless of this qualification, in the short time practice nursing has been actively promoted as a viable profession and as a means to relieve workforce shortages in general practice, (albeit partially), it has been well accepted by general practitioners.

Further development of the practice nursing profession is needed to ensure it will continue to evolve to meet the requirements of changing health needs and patient groups. A number of strategies appear to be in place to accommodate this need. However, a number of issues, such as those surrounding regulatory and legislative constraints on the tasks practice nurses can undertake, as well as those relating to long-standing professional animosities, need to be resolved.

## Developing practice nursing:

### Nursing in General Practice Initiative

#### Initial program

In 2001/02 the Australian Government provided funding to a Nursing in General Practice Initiative (NiGP Initiative) over a four year period. This program was part of an overall government strategy to improve access to medical services for patients in rural Australia. The NiGP Initiative was to contribute to the strategy by providing financial incentives for general practitioners to employ practice nurses.

The initial NiGP Initiative consisted of three components:

- A practice incentive payment component. Funding of \$86.6 million was available through this component for the payment of incentives to Practice Incentive Payment (PIP)<sup>37</sup> eligible general practices to encourage these practices to employ practice nurses and/or Aboriginal Health Workers.

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36. *ibid.*

37. The PIP recognises general practices that provide comprehensive, quality care and which are, either accredited or working towards accreditation, against the Royal Australian College of General Practitioners' (RACGP) *Standards for General Practices*.

PIP payments made through the program are in addition to other income earned by the general practitioners and the practice, such as patient payments and Medicare rebates. Payments focus on aspects of general practice that contribute to quality care. PIP payments are mainly dependent on practice size, in terms of patients seen, rather than on the number of consultations performed.

- A training and support component. Funding of \$12.5 million under this component was provided to develop the practice nurse role and to improve support structures for practice nursing. Five priority areas were identified under this component:
  - Informing consumers, nurses and general practitioners about nursing in general practice and about the NiGP Initiative
  - improving the capacity of Divisions of General Practice to support nursing in general practice
  - making training for practice nurses more available and accessible
  - encouraging nursing networks and mentoring systems and
  - providing an effective evaluation of the Initiative.
- The third component, a Rural and Remote Nurse Re-entry and Upskilling Scholarship Scheme was funded with \$5.2 million.

The scholarship component was established to encourage former nurses within rural and remote Australia to return to the nursing workforce<sup>38</sup> and did not target practice nurses exclusively.

## Evaluation

In 2005, Healthcare Management Advisors (HMA) was commissioned by the Australian Government to evaluate the NiGP Initiative. HMA concluded that the Initiative had been successful in helping to increase the number of practice nurses employed in general practices.

The table below shows the proportion of PIP practices employing practice nurses under the NiGP by Rural, Remote and Metropolitan Area (RRMA) classification by quarter from February 2002 to February 2004.

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38. Healthcare Management Advisors, *Evaluation of the 2001 Nursing in General Practice Initiative*, June 2005, (HMA report), [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/638EA76A2353AC6BCA257070002AB1C8/\\$File/eval.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/638EA76A2353AC6BCA257070002AB1C8/$File/eval.pdf) accessed 6 March 2007.

## Proportion of PIP practices accessing the NiGP by RRMA

RRMA	Feb-02	May-02	Aug-02	Nov-02	Feb-03	May-03	Aug-03	Nov-03	Feb-04
1	26%	30%	40%	45%	45%	45%	43%	43%	48%
2	29%	43%	48%	45%	52%	55%	56%	59%	64%
3	55%	61%	65%	66%	66%	69%	69%	71%	71%
4	62%	66%	69%	69%	70%	71%	74%	75%	75%
5	56%	60%	65%	67%	68%	69%	70%	73%	74%
6	47%	51%	62%	67%	73%	71%	71%	70%	72%
7	47%	47%	53%	52%	49%	52%	52%	49%	50%
Total	55%	59%	64%	65%	66%	68%	69%	70%	71%

Source: HMA report<sup>39</sup>.

(Note:

RRMA classification – RRMA allocates each Statistical Local Area (SLA) within capital cities and metropolitan centres (having a population of 100,000 or more) as metropolitan or RRMA 1 and 2. Other SLAs are defined as Rural or Remote based on an index of remoteness. The index is calculated by combining factors relating to population density and distance. RRMA 7 is the most remote classification).<sup>40</sup>

HMA found further that the Initiative had helped to improve the capacity of Divisions of General Practice to provide support to practice nursing. In addition, employment of practice nurses under the Initiative had:

- Improved the throughput of patients in general practices which employed practice nurses and reduced patient waiting times
- given general practitioners more available time and reduced their workforce pressures
- provided opportunities for rural general practitioners to liaise more effectively with other health professionals about the care of patients and
- increased patient awareness of practice nurses, raised their profile and encouraged the idea that they should receive specific practice nurse education.<sup>41</sup>

Overall, HMA concluded that practice nurses made a significant contribution to the quality, access and affordability of primary health care in Australia and that other incentives to encourage general practices to employ practice nurses needed to continue into the future.<sup>42</sup>

39. HMA report, op. cit.

40. See <http://www.health.gov.au/internet/wcms/publishing.nsf/content/work-mrb-info07-toc~work-mrb-info07-rrma> for further detail, accessed 20 March 2007.

41. *ibid.*

## Continuation

In response to the HMA report, the government provided funding in the 2005/06 Budget of \$129.7 million over an additional four years to maintain the substance of the NiGP Initiative. The PIP incentive component of the program received a further \$112.4 million in the Budget and the training and professional support programs component was funded for \$15.6 million.

The scholarship component that had been previously funded was incorporated into the Australian Rural and Remote Nurse Scholarship Program.

The PIP component of the NiGP Initiative had previously been enhanced under the *Strengthening Medicare* package in 2003. This package varied eligibility criteria for the component so that an additional 650 general practices in urban areas of workforce shortage became eligible to employ practice nurses. An extra \$78.5 million for the component over four years included \$5.5 million for practice nurse training.<sup>43</sup>

In addition, \$2.6 million over the same four year period was provided for practice nurses in regional and rural areas to receive training to assist them to identify and respond to domestic violence as part of a \$75.7 million *Women's Safety Agenda*.<sup>44</sup> General practitioners also received assistance to release the practice nurses they employed for this training.

## Medicare items

In 2004, also as part of *Strengthening Medicare*, the Australian Government introduced Medical Benefits Schedule (MBS) items for practice nurses who provide immunisations and wound care on behalf of general practitioners. Doctors retained responsibility for the provision of these services, however, and patients were entitled to request that the services were performed by general practitioners.

In January 2005, a further MBS item for practice nurses who undertook pap smears on behalf of doctors in rural areas was introduced. This was extended to urban areas in November 2006.<sup>45</sup>

In July 2005, Chronic Disease Management items which involved practice nursing were introduced.<sup>46</sup> These items allow general practitioners to be assisted by practice nurses in

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42. *ibid.*

43. See Department of Health and Ageing, 'Nursing initiatives', [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-nursing\\_initiatives.htm](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/factsheet-nursing_initiatives.htm) accessed 20 March 2007.

44. See Office for Women website for details of program, [http://www.ofw.facs.gov.au/womens\\_safety\\_agenda/index.htm](http://www.ofw.facs.gov.au/womens_safety_agenda/index.htm) accessed 20 March 2007.

45. The Hon. Tony Abbott, Minister for Health and Ageing, media release, 1 November 2006.



developing and maintaining GP Management Plans. Under these plans, patients' illnesses are assessed, goals for management of conditions are agreed and patient actions, treatment and services to be provided are identified.<sup>47</sup>

From November 2006, a Medicare rebate for antenatal care delivered by midwives, nurses and registered Aboriginal health workers in rural areas on behalf of general practitioners or specialists was also made available. This item does not include delivery or the management of labour and does not replace antenatal care that may be considered more appropriately provided by a medical practitioner.<sup>48</sup>

Over seven million services have been delivered by practice nurses since the introduction of these items. These include more than four million immunisations and two million wound management services.<sup>49</sup>

## Standards, information and support

Clearly, if practice nursing is to continue to contribute to better health outcomes, it is important that the government recognition and support the specialty has received through the NiCP Initiative is supplemented and continued. It is equally important in ensuring a holistic development of practice nursing that practice nurses are aware of the skills they require and that they are confident they can obtain those skills. So too, it is important that professional, long-term support mechanisms are in place to sustain, guide and inform practice nurses and other professionals with whom they work.

## Competency standards

In achieving these aims for a future practice nursing workforce, in 2005 the RCNA developed national competency standards under a project funded by the Department of Health and

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46. See items at [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/\\$File/CDM%20item%20descriptors%20extract%20from%201Nov%202006%20MBS%20Book.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/$File/CDM%20item%20descriptors%20extract%20from%201Nov%202006%20MBS%20Book.pdf) accessed 20 March 2007.
  47. See chronic disease management items at [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/\\$File/factsheet.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/$File/factsheet.pdf) accessed 20 March 2007.
  48. The Hon. Tony Abbott, Minister for Health and Ageing, media release, op. cit.
  49. See Medicare statistics at [http://www.medicare.gov.au/cgi-bin/broker.exe?PROGRAM=dyn\\_mbs.mbs\\_tab4.sas&SERVICE=default&DRILL=ag&DEBUG=0&GROUP=10993%2C10996%2C10998%2C10999&VAR=services&STAT=count&RPT\\_FMT=by+state&PTYPE=finyear&START\\_DT=200007&END\\_DT=200606](http://www.medicare.gov.au/cgi-bin/broker.exe?PROGRAM=dyn_mbs.mbs_tab4.sas&SERVICE=default&DRILL=ag&DEBUG=0&GROUP=10993%2C10996%2C10998%2C10999&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=200007&END_DT=200606) accessed 11 April 2007.

Ageing. The RCNA has argued that standards are an important framework to assist nurses to assess their practice and guide their professional development. The standards are not a 'stand alone' set of competencies, they are intended to be used in conjunction with other core competency standards developed by the Australian Nursing and Midwifery Council and endorsed by nurse regulatory authorities in each state and territory.<sup>50</sup>

There are two sets of competency standards now in place – one for registered nurses; the other for enrolled nurses.<sup>51</sup>

The competency standards for registered nurses emphasise the need for practice nurses to operate in accordance with nursing and general practice codes and guidelines and with regulatory and legislative requirements. In addition, amongst other things they require practice nurses to improve and maintain their nursing skills, work cooperatively within general practice teams and strive always to deliver optimal patient care.<sup>52</sup>

The standards for enrolled nurses are similar to those of registered nurses but with some provisos in accordance with supervisory requirements placed on these nurses by various nurse regulatory bodies.

## Information

An interpretive toolkit has also been developed to accompany the nursing standards to assist nurses, general practitioners and training providers. The toolkit provides nurses with a self assessment tool, a sample professional development plan and resources to help use the competency standards. It provides general practitioners with sample job descriptions and assistance to review the scope of nursing practice for nurses they employ.<sup>53</sup>

A guide for nurses and general practitioners was developed in 2001. It defines roles and responsibilities for practice nurses and provides information on other aspects of practice nursing, including information on legislative and regulatory requirements.<sup>54</sup> The guide emphasises the positive health outcomes for general practices from employing practice nurses. It notes not only the improved quality of care that can be gained, but also that practice

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50. Australian Nursing Federation, *Competency standards for nurses in general practice*, 2006, [http://www.anf.org.au/nurses\\_gp/resource\\_03.pdf](http://www.anf.org.au/nurses_gp/resource_03.pdf) accessed 8 March 2007.

51. See [http://www.anmc.org.au/docs/Competency\\_standards\\_RN.pdf](http://www.anmc.org.au/docs/Competency_standards_RN.pdf) for competency standards for registered nurses and <http://www.anmc.org.au/docs/Competency%20standards%20for%20the%20Enrolled%20Nurse.pdf> for competency standards for enrolled nurses, accessed 14 June 2007.

52. *ibid.*

53. See <http://www.anf.org.au/nurses%5Fgp/> accessed 2 April 2007.

54. RCNA, *Nursing in general practice. A guide for the general practice team*, update of 2001 guide, <http://www.rcna.org.au/content/screenrez.pdf> accessed 8 March 2007

nurses provide an opportunity to institute a multi disciplinary approach in general practice which can enable practices to increase services to the community, through targeted or condition-specific clinics for example. Additionally, the guide points out that employment of practice nurses can be used as an additional incentive when recruiting new general practitioners to practices.<sup>55</sup>

### Support from representative body

A key representative body for practice nurses was established in 2001. This body, the Australian Practice Nurses Association (APNA) provides representation, support and networks at local, state and national levels for nurses in general practice. The APNA currently has over 1100 members.<sup>56</sup>

The APNA vision for the development of practice nursing is for practice nurses to be recognised as professional members of collaborative teams and for these nurses to be seen as playing a key role in management of patient health. At the same time, the APNA is concerned that practice nurses are appropriately remunerated and that they have a voice in determining health policy.<sup>57</sup>

The following table from the APNA website highlights the aims of the APNA and the strategies it is undertaking to achieve its vision for practice nursing.

#### Australian Practice Nurse Association – objectives and strategies for practice nursing

Objectives	Strategies		
<b>Supporting members to be recognised</b>	Increase support for general practice nurse research	Increase APNA and practice nurse profile	Encourage and undertake effective policy development and representation
<b>Supporting members to be professional</b>	Develop and provide Continuing Professional Development	Provide professional indemnity insurance	Provide high quality, accessible and affordable education
<b>Supporting members to become empowered</b>	Support development and maintenance of local branch Networks	Provide information and support business acumen development	Advocate effectively on behalf of members

Source: APNA<sup>58</sup>

55. Australian General Practice Network, *Nursing in general practice. Business case models – Information sheet*, 2005, <http://www.adgp.com.au/site/index.cfm?display=4002&filter=i&leca=71&did=27843450> accessed 8 March 2007.
56. See website at <http://www.apna.asn.au/> accessed 8 March 2007.
57. *ibid.*
58. See <http://www.apna.asn.au/displaycommon.cfm?an=1&subarticlenbr=23> accessed 4 April 2007.

APNA began an online learning service for practice nurses in November 2006. The service delivers a range of training from short courses to formal qualifications in areas specific to the general practice clinical and business environment.<sup>59</sup>

## Mentoring

Mentoring in practice nursing has been seen as important in developing the discipline due to the isolated nature of the nursing professional experience in this speciality. In examining possibilities for mentoring, researchers from the University of South Australia found there were challenges in establishing effective mentoring. These stem not only from the fragmentation of the sector, but also from variation in size and structure of practices and the diversity in nursing roles in general practice.<sup>60</sup> The researchers concluded that appropriate resourcing and infrastructure needed to be in place to deal with personal development issues, professional relationship management and overall learning to assist nurses to work in the general practice environment.

A National Mentoring Framework has been developed from the University of South Australia research that identifies existing mentoring mechanisms and suggests options for addressing future needs in practice nursing.

## Support from Divisions of General Practice

The ADGP has been particularly active in promoting the employment of practice nurses amongst its members. It has also worked in cooperation with state divisions of general practice to this end. In 2003, the ADGP developed a series of business case models to assist general practices in assessing the benefits and implications of employing practice nurses.<sup>61</sup>

It also supervised a demonstration project involving a series of workshops and the development of a resource kit. The kit cited various models for employment of practice nurses and documented barriers employers may encounter in employing these nurses.<sup>62</sup>

In addition, the ADGP introduced a position of Principal Policy Advisor on Nursing in General Practice. This position was intended to foster the development of effective linkages

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59. *ibid.*

60. M. Heartfield, T. Gibson, C. Chesterman and L. Tagg, *Hanging from a string in the wind. Development of a national framework for mentoring for nurses in general practice*, June 2005. [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/33FFB442CF59B746CA257070002C8EA7/\\$File/natframe.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/33FFB442CF59B746CA257070002C8EA7/$File/natframe.pdf) accessed 8 March 2007.

61. *Nursing in general practice. Business case models*, op. cit.

62. ADGP Demonstration Divisions, 'Nursing in general practice national resource kit', [http://www.adgp.com.au/client\\_images/24936.pdf](http://www.adgp.com.au/client_images/24936.pdf) accessed 9 March 2007

with practice nurse coordinators within Divisions, promote nursing in general practice and provide strategic policy advice.<sup>63</sup>

Divisions have also worked cooperatively to promote the NiGP Initiative and to develop a national approach and consistent standards that can be applied by general practitioners to the employment of practice nurses.

It is expected that by 2009, the NiGP Initiative and the work done by the ADGP and state based organisations will have contributed significantly to the employment of more practice nurses.<sup>64</sup>

## Future considerations

### Education

As noted earlier in this paper, development of clear educational pathways and support mechanisms has been recognised for some time overseas, and more recently in Australia, as essential in ensuring that practice nurses are able to continue to enhance the quality of care delivered in a general practice setting.<sup>65</sup>

All indications are also that practice nurses will be required to possess broader clinical knowledge and other skills to cope with the types of activities they may be called upon to deal with in general practice in the future. So the reality of practice nurses currently not being prepared 'to meet the knowledge requirements of the nurse working in the general practice team of the future'<sup>66</sup> needs to be addressed as a priority in the ongoing development of this nursing specialty.

The norm has been however, that general practice specific clinical education for practice nurses has traditionally been obtained 'on the job'. While there have been some clinical educational programs available to assist practice nurses to improve clinical care skills, many of these have not been accredited or evaluated. This situation is gradually changing with the introduction of short and targeted accredited courses, in the manner of those offered by the APNA.

Likewise, formal tertiary clinical education initiatives, such as those supported by the ADGP and other divisions of general practice, have been introduced to encourage nurses to view

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63. See profile at <http://www.cdmcalgary.ca/Default.aspx?tabid=62> accessed 16 March 2007.

64. See <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-nurse-training-support0509> accessed 16 March 2007.

65. Watts et al., op. cit.

66. *ibid.*

practice nursing as a viable career option. The University of the Sunshine Coast and the Sunshine Coast Division of General Practice for example have developed graduate certificates in general practice nursing.<sup>67</sup> Other Universities also offer practice nursing courses or practice nursing units in the context of postgraduate courses.<sup>68</sup> Such programs are formally assessed.<sup>69</sup> Importantly, the Australian Government has begun to recognise the value of these courses and has provided scholarship assistance.<sup>70</sup>

In conjunction with these types of programs, it has been argued that education for practice nurses needs to involve a nationally consistent education system in specific areas to ensure that general practice needs in wound care, first aid/CPR, oxygen administration, pharmacology administration and pathology collection education are fulfilled.<sup>71</sup> It could be argued further that such specific training in conjunction with nationally consistent standards is vital, given the expanded role for practice nurses, which has resulted from the introduction of Medicare items in immunisation and wound management.<sup>72</sup>

Additionally, some overseas research has suggested that increasing the exposure of student nurses to nursing in general practice through structured practice placements would complement formalised education.<sup>73</sup>

Overseas studies have found that despite the existence of formalised training for practice nurses, other educational barriers persist. These include access to study leave, protected learning time and funding for continuing education.<sup>74</sup> These need also to be addressed.

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67. See <http://www.adgp.com.au/site/index.cfm?display=21937> for explanation of certificate, accessed 16 March 2007.
  68. For example, as part of the University of Queensland Master of Nursing degree, [http://www.uq.edu.au/study/plan.html?acad\\_plan=GNURX5383](http://www.uq.edu.au/study/plan.html?acad_plan=GNURX5383) accessed 11 April 2007.
  69. Courses are offered at other institutions also, for example, at Wollongong University and Edith Cowan University <http://southwest.ecu.edu.au/nursing/gradcert.html> and [http://www.uow.edu.au/health/nursing/pdf/gradcert\\_practnurse2.pdf](http://www.uow.edu.au/health/nursing/pdf/gradcert_practnurse2.pdf) accessed 6 March 2007.
  70. A government scholarship of up to \$10,000 may be available for post graduate study towards a certificate, diploma or masters or doctorate under funding. The scholarship is administered by the APNA.
  71. Watts et al., op. cit.
  72. Currently the APNA manages a scholarship scheme under which \$1500 is available for practice nurses for continuing education in areas such as women's health, mental health, cholesterol management and nutrition.
  73. Scottish Executive, *Framework for nursing in general practice*, <http://www.scotland.gov.uk/Publications/2004/09/19966/43290> accessed 15 June 2007.
  74. *ibid.*

In terms of administration, as the RACGP/RCNA Report has noted, some practice nurses have qualifications in areas outside nursing which assist them in this aspect of their work. However, as with clinical skills, it has been usual that most practice nurses acquired their expertise in administration, integration and other activities incidentally. The RACGP/RCNA Report acknowledges that it is unreasonable to expect undergraduate education to prepare all nurses for a general practice role in population health or health promotion.<sup>75</sup> But at the same time, it seems reasonably clear that these are essential qualifications for practice nurses.

This lack of specific skills is, to some extent, being addressed. The University of New England, for example, has introduced a nurse leadership program which aims to develop the leadership skills of practice nurses to enable their effective involvement in the planning and delivery of primary care services and the development of their profession.

More needs to be done to refine practice nurse training. The framework noted by the RACGP/RCNA clearly indicates the complexity of this task. The Report concludes, as is also noted throughout this paper, that practice nursing needs to be general practice specific and that it needs to be offered as a career option. It iterates also that practice nursing education for the future should promote clinical and theoretical competence through appropriate standards of assessment.<sup>76</sup>

Importantly, the Report argues that education for practice nurses needs to be sustained by general practice itself, and as such, practices need to be assisted to ensure the right education systems are in place for practice nurses.<sup>77</sup>

In terms of continuing education also it may be that a variant of the system that has existed since 1989 as a requirement for vocational registration<sup>78</sup> of general practitioners could be considered for practice nurses. General practitioners can receive Continuing Professional Development (CPD) points for attending workshops, seminars, presentations and short courses as well as for the completion of more rigorous academic courses and clinical education modules.<sup>79</sup>

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75. Watts et al., op. cit.

76. *ibid.*

77. *ibid.*

78. Doctors are generally eligible for vocational registration if they are Fellows of the RACGP. Vocational registration gives access to general practice specific billing items listed in the Medicare Benefits Schedule. Services provided by doctors without vocational registration do not attract full Medicare rebates. To maintain vocational registration, doctors need to undertake continuing medical education.

79. RACGP, *QA&CPD Program Handbook, 2005-2007 Triennium*, <http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/QACPD/20052007TrienniumProgramHandbookandSummaryCard/2005qahandbook.pdf> accessed 12 April 2007.

Currently, the APNA promotes a voluntary CPD program. The program assists practice nurses in identifying, completing and recording job-specific learning. There is currently no CPD national registration requirement for nurses as there is for general practitioners, but the APNA notes that states and territories are gradually moving towards this option.<sup>80</sup>

An alternative nursing variant of CPD points could possibly be linked to an incentive payment for nurses, rather than to registration (see reference later in this paper to nursing remuneration issues).

## Consumer perceptions

For practice nurses to become an unquestioned and integral part of the general practice environment, patients need to understand that nurses are autonomous qualified health professionals.

In 2002, a University of South Australia study found that patients were largely unaware of the role nurses played, or could play in general practice. Patients' understandings of the role for nurses in this setting was particularly informed by their view of general practice as 'sickness care' – a system they accessed when they needed 'a specific service for their ill health or injury rather than a system for preventative health care'.<sup>81</sup>

Consequently, patients perceived nurses as competent employees of general practitioners, not as medical professionals in their own right. Patients were generally unaware of the various levels of nursing qualifications, registration or specialities.<sup>82</sup> They expressed concern that nurses may act as 'gatekeepers' who took away consumer choice by preventing access to general practitioners and they did not want nurses to substitute for doctors in undertaking diagnosis. They were firmly of the view that the use of nursing services in general practice should not increase costs to consumers.<sup>83</sup>

In effect, the South Australian study emphasised that patients needed to be informed about the practice nurse role, the 'wellness' benefits practice nurses can deliver in health promotion and the chronic disease management role they can play for an increasing number of people.

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80. Nurses in Western Australia, Queensland, Victoria and Tasmania are audited by their regulatory authorities for evidence of CPD involvement  
<http://www.apna.asn.au/displaycommon.cfm?an=1&subarticlenbr=100> accessed 4 September 2007.

81. Centre for Research into Nursing and Health Care, University of South Australia, *Consumer perceptions of nursing and nurses in general practice*, November 2002,  
[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-nursing-consrep.htm/\\$FILE/repfin.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-nursing-consrep.htm/$FILE/repfin.pdf) accessed 16 March 2007.

82. *ibid.*

83. *ibid.*



The University of South Australia study recommended a number of strategies to begin to achieve these goals, including general practitioners 'brokering' of attitudinal change with regard to the contribution practice nurses can make to enhanced primary care.

It appears the NiGP Initiative has made some contribution to changing these attitudes. As noted elsewhere in this paper, the Initiative has raised the profile of practice nurses and demonstrated the potential that this profession has to improve patient outcomes. But consumer education most likely needs to be ongoing and more innovative as the role of practice nursing expands in the future.

### **Further study**

A General Practice Nurses Study commenced in 2005. The study is being undertaken collaboratively by the Australian Divisions of General Practice and the Australian National University with funding from the Australian Primary Health Care Research Institute. The study will spend three years examining the roles of nurses in general practice. Researchers expect the study will deliver a better understanding of the processes and work practices of general practice nurses.

The study will consider local, individual and structural factors that influence the work of practice nurses. It intends also to examine 'the ways in which practice nurses contribute to the overall safety and quality of general practice services'.<sup>84</sup> Ultimately, it is expected the study will suggest new models for practice nursing.

In addition, other studies have been funded under the National Competitive Grants Scheme to explore the potential of expanded roles for nurses in general practice. These include a grant to the University of Queensland over three years from 2007 to consider the feasibility, acceptability and cost effectiveness of nurse led models of chronic disease management in general practice.<sup>85</sup> Findings from such studies may also result in the emergence of new models for practice nursing generally.

### **Other issues**

The RACGP/ACNA study undertaken in 2004 identified a number of issues it believed impacted significantly on nursing in general practice. Some of these, such as the issue of recognition of practice nursing as a distinct specialisation, are now beginning to be addressed. Others remain problematic.

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84. See Australian general practice nurses study website at [http://homepage.mac.com/chris\\_pearce/AGPNS/index.htm](http://homepage.mac.com/chris_pearce/AGPNS/index.htm) accessed 15 March 2007.

85. See summary of Discovery Projects proposals for 2007, Australian Research Council Grants at [http://www.arc.gov.au/PDF/DP07/DP07\\_QLD\\_Uni.pdf](http://www.arc.gov.au/PDF/DP07/DP07_QLD_Uni.pdf) accessed 15 July 2007.

## Health system and nursing workforce issues

How the health system should accommodate a greater role for nursing in general practice is one such issue. As noted earlier in this paper, changing demographics and the emergence of additional demands on the health system in recent times have affected the delivery of health services generally. In primary care for instance, there has been a shift away from treating illness to adopting preventative health and health promotion strategies. There are multiple intentions and aims in this focus shift. These include the intention to produce better health outcomes for an ageing population and delay and reduce healthcare costs in secondary and tertiary medical care.

Adopting a more preventative focus has inevitably changed the nature of general practice, however. For nurses, this has meant greater opportunities to vary the work they undertake, but at the same time it has increased their workload. In conjunction with the change in emphasis, improvements in technology have also meant that potentially, nurses can expand the tasks they undertake in general practice even further. At the same time, technological change has brought with it the need for nurses to gain more skills and sophisticated understandings of illnesses and treatments.

This has occurred in an environment where the nursing workforce is ageing.<sup>86</sup> Consequently, there are questions about whether there will be sufficient numbers of nurses in the short term to undertake enhanced roles that may be envisaged for them, regardless of whether these will be in practice nursing or other specialties. In the longer term, the situation may be equally problematic. This is despite recent government commitments to funding considerable increases in nursing training places.<sup>87</sup> Issues such as overall retention and job satisfaction in the nursing profession in general remain unresolved. Solutions will need to be found to ensure that the numbers of nurses will meet expected demand for their services.

Retention and job satisfaction are related factors. Nurses leave the nursing profession for a number of reasons. Perhaps the most reported of these is that they consider their rates of pay low in comparison with other health professionals and in relation to the skill levels nursing

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86. In 2001, the average age of nurses was 42.2 years. Australian Health Workforce Advisory Committee, *Nursing workforce planning in Australia*, March 2004, [http://www.health.nsw.gov.au/amwac/pdf/nurse\\_plan\\_20041.pdf](http://www.health.nsw.gov.au/amwac/pdf/nurse_plan_20041.pdf) accessed 12 April 2007.

87. For example, in July 2006 the Australian government announced (The Hon. John Howard, Prime Minister, media release 13 July 2006, [http://www.pm.gov.au/media/Release/2006/media\\_Release2018.cfm](http://www.pm.gov.au/media/Release/2006/media_Release2018.cfm)) that 1036 nursing places additional to increased places already committed to in 2005 would be funded over four years at a cost of \$93 million. In addition, the government committed to providing about \$31 million over four years to increase its contribution toward the cost of nurses' clinical training from about \$690 to \$1,000 a year per full-time student. Council of Australian Governments communiqué, 14 July 2006, <http://www.coag.gov.au/meetings/140706/index.htm#mental> accessed 12 April 2007.

demands.<sup>88</sup> It is not within the scope of this paper to discuss remuneration or job satisfaction for nurses in detail. It is, however, important to note that the issue of remuneration is intimately linked to perceptions about skills requirement and acquisition. Given that the need for greater skills for nurses and the ability to acquire them quickly to cope with technological advances will increase in the future, it is possible the nursing profession's dissatisfaction over rates of pay will also intensify.<sup>89</sup>

There are other reasons which nurses cite for not continuing in the nursing profession that are perhaps as important as remuneration. A number of surveys have indicated that a lack of career path for experienced nurses, overwork, staff shortages, frustration, physical and emotional exhaustion and perceptions that their work is undervalued and unappreciated and that they are not respected by doctors, may contribute more to attrition than pay.<sup>90</sup>

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88. Australian Centre for Industrial Relations Research and Training, *Stop telling us to cope! A report prepared for the NSW Nurses' Association*, May 2002, <http://www.nswnurses.asn.au/documents/3240/extract/index-Key-3.html> accessed 12 April 2007.
89. The 2002 report for the New South Wales Nurses Association, op. cit., argued for example that nurses' pay is unfair in comparison with other health professionals and that this is due to the changing nature of nursing work. A random study of nurses in Western Australia also found that 80 per cent of participants considered nursing pay low relative to other health industry jobs requiring similar skills and almost 90 per cent considered nurses' pay low relative to jobs requiring similar skills and responsibilities in other industries. Interestingly, while this study reported these survey results, it concluded that 'estimated wage functions suggest nurses' earnings are not very much different to those of other women when controlling for factors such as level of education and experience' A. Dockery, *Workforce experience and retention in nursing in Australia*, Women's Economic Policy Analysis Unit, Curtin University of Technology, 2004, [http://www.cbs.curtin.edu.au/files/WEPAU\\_WP-33\\_April\\_2004.pdf](http://www.cbs.curtin.edu.au/files/WEPAU_WP-33_April_2004.pdf) accessed 12 April 2007. Note: according to the Australian Bureau of Statistics (ABS), in 2001 91 per cent of nurses were female. In relation to remuneration the ABS also notes that in 2004, full-time, adult, non-managerial nursing professionals earned \$1028.30 per week on average excluding overtime, and enrolled nurses earned \$715.30 per week. In comparison, the average earnings per week across all full-time adult non-managerial employees were \$867.50, <http://www.abs.gov.au/ausstats/abs@.nsf/2f762f95845417aeca25706c00834efa/8a87ef112b5bcf8bca25703b0080ccd9!OpenDocument> accessed 12 April 2007.
90. For example: Senate Standing Committee on Community Affairs, *Report on the Inquiry into Nursing, the patient profession. Time for action*, 2002, [http://www.aph.gov.au/Senate/committee/clac\\_ctte/completed\\_inquiries/2002-04/nursing/report/](http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2002-04/nursing/report/) accessed 13 April 2007. Report for the New South Wales Nursing Association, op. cit., and a survey of Directors of Nursing and Chief Executive Officers, conducted by Aged and Community Services, Tasmania (2001) giving the most cited reason for nurses leaving aged care as workload/burnout. National Review of Nursing Education, *Discussion paper*, 2001,

It is likely that practice nurses also experience similar situations or reach similar conclusions as nurses in general. It may be argued that because of a lack of clear definition about what the practice nurse role encompasses, that these nurses may be more frustrated. Further, issues such as undervaluation of the work nurses perform in general practice due to the lack of definition regarding what constitutes and/or should constitute supervision, may even be more problematic for practice nurses.

Indeed, it can be argued that the issues of retention and dissatisfaction may be compounded for practice nursing by the employer/employee relationship that currently dominates in general practice. In this vein, the National Association of Independent Nurses in Britain claims that encouraging more nurses to act as contractors rather than employees will not only lead to substantial increases in income and professional autonomy, but it will help in the recognition of nursing as a 'true profession'.<sup>91</sup>

Some efforts have been made to address the shortage of nurses. The Australian Government has increased undergraduate nursing places significantly in recent times. Its latest commitment of over 1000 new nursing places under the Backing Australia's Future<sup>92</sup> program was made in July 2006, with the first of these students commencing study in 2007.<sup>93</sup>

In addition, the government has introduced scholarships and programs to encourage nurses who have left the profession to return, as well as scholarships for undergraduate nursing studies. These include the Commonwealth Undergraduate Rural and Remote Nursing Scholarship Scheme<sup>94</sup> for undergraduates and the NiGP Initiative re-entry scholarship<sup>95</sup> noted earlier in this paper.

While these initiatives have the potential to increase the numbers of nurses *per se*, there are few specific initiatives aimed at encouraging nurses to enter practice nursing or to return to nursing in a practice nursing role. However, because of the nature of practice nursing, there may be opportunities which have yet to be explored to encourage nurses who have moved to

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<http://www.dest.gov.au/archive/highered/nursing/pubs/discussion/chap6.htm#4>  
accessed 13 April 2007.

91. See the website of the National Association of Independent Nurses at <http://www.independentrn.com/> accessed 15 June 2007.
92. See 'Our universities. Backing Australia's future', May 2003, policy document at [http://www.backingaustraliasfuture.gov.au/policy\\_paper/policy\\_paper.pdf](http://www.backingaustraliasfuture.gov.au/policy_paper/policy_paper.pdf) accessed 15 June 2007.
93. The Hon. John Howard, Prime Minister, media release, 13 July 2006, [http://www.pm.gov.au/media/release/2006/media\\_Release2018.cfm](http://www.pm.gov.au/media/release/2006/media_Release2018.cfm) accessed 15 July 2007.
94. See <http://www.med.monash.edu.au/nursing/geninfo/scholarships-ugrad.html> for details of this scholarship, accessed 15 June 2007.
95. See <http://www.rcna.org.au/pages/mnress.php> for details, accessed 15 June 2007.

other jobs in the health sector, such as health education, sales of medical equipment and supplies or clinical research to return to practice nursing.

The following table illustrates the considerable number of nurses working in other professions.

#### Labour Force Status of Females (A) with Nursing Qualifications (B) - 2001

	<b>Females</b>
	%
Employed	83.5
Nursing professional	61.3
Other occupation	22.3
Unemployed	1.0
Not in the labour force	15.5
<b>Total</b>	<b>100.0</b>
	'000
<b>Total</b>	<b>183.4</b>
	%
Unemployment rate	1.2

(a) Aged 15-64 years.

(b) Bachelor degree or higher in a nursing field.

Source: ABS Study of Education and Training 2001<sup>96</sup>

The nursing workforce situation illustrates the need for more far-sighted thinking about how the health system generally will cope with change into the future. Carol Gaston cites the example of the health system currently under stress because of its continued dependence on acute hospitals to service health care needs. Despite this situation the growth in chronic disease requires that structures are in place in the community to enable the management of chronic conditions at a local level. This means changing the profile and role of some hospitals to provide for a networked hierarchy of services as well as redeveloping other hospitals to provide for short-term stays and community rehabilitation.<sup>97</sup> Gaston concludes that:

Making these changes will take time and will require strong leadership to lead a change management process. Leaders across the health system will need to make a commitment to a

96. See Australian Bureau of Statistics information at <http://www.abs.gov.au/ausstats/abs@.nsf/94713ad445ff1425ca25682000192af2/8a87ef112b5bcf8bca25703b0080ccd9!OpenDocument> accessed 15 June 2007. Note Australian Institute of Health and Welfare statistics differ from those presented in the table cited. These indicate that 10.2 per cent of the nursing workforce was employed elsewhere, not looking for work or was overseas. <http://www.aihw.gov.au/publications/hwl/nmlf03/nmlf03.pdf> accessed 15 June 2007. Regardless of this discrepancy, both studies indicate that there are a significant number of nurses in this pool.

97. C. Gaston, 'Nurses leading health system reform', <http://www.joannabriggs.edu.au/services/durbin/durbin8.htm> accessed 7 August 2007.

better way of doing business, have the courage to challenge existing power bases and norms, and be willing to take the initiative to go beyond defined boundaries.<sup>98</sup>

Papers presented at the National Health Reform Summit in July 2007 make similar points.<sup>99</sup> New primary health care models will need to be developed that address the social determinants of health and operate within the context of wider population health needs. From an overall health workforce perspective, the Summit papers conclude this must entail a whole of government approach not only for nurses, but for all health professionals. As one paper observes:

The way the health workforce is educated, regulated and works is inextricably linked to the way health care is funded and provided and effective workforce planning can only be achieved if structural changes are made by government.<sup>100</sup>

### Regulatory issues

Legislative and regulatory issues in relation to the actual and potential role and scope of practice nursing may be an issue for the future.

### Administration of medicines

To date, however, in spite of the reality that states and territories have different legislation governing the administration of medicine, little consideration has been given to how legislative requirements affect the practice nurse specialty.<sup>101</sup> For example, in Tasmania, nurses need to be registered as nurse immunisers to provide immunisations under the supervision of a general practitioner.<sup>102</sup> In Queensland, appropriately trained and registered nurses are considered nurse immunisers and are able to provide immunisations in accordance with certain protocols.<sup>103</sup> In the Australian Capital Territory (ACT) nurses are able to provide

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98. *ibid.*

99. Australian Health Care Reform Alliance, Position Papers, July 2007, [http://www.healthreform.org.au/content/upload/files/Microsoft\\_Word\\_-\\_Position\\_papers\\_July\\_2007\\_Summit.pdf](http://www.healthreform.org.au/content/upload/files/Microsoft_Word_-_Position_papers_July_2007_Summit.pdf) accessed 7 August 2007.

100. *ibid.*

101. Watts et al., *op. cit.*

102. Department of Health and Human Services, *Immunisation in Tasmania. Evaluation of the nurse immuniser role*, May 2006, [http://www.nursingboardtas.org.au/nbtonline.nsf/attachment/NurImmEval/\\$File/Final%20Report%20Immunisation%20in%20Tasmania%20Evaluation%20of%20Nurse%20Immuniser%20Role.pdf](http://www.nursingboardtas.org.au/nbtonline.nsf/attachment/NurImmEval/$File/Final%20Report%20Immunisation%20in%20Tasmania%20Evaluation%20of%20Nurse%20Immuniser%20Role.pdf) accessed 15 May 2007.

103. In Queensland, for example, Registered Nurses are able to apply for endorsement by the Queensland Nursing Council as nurse immunisers on completion of an accredited program. They are then permitted to act under the Health (Drugs and Poisons) Regulation 1996, section

immunisations under a standing order that is signed by the Medical Director of the ACT Population Health Unit.<sup>104</sup> Clearly, such diverse regulations can have implications for the scope of practice for nurses working in different jurisdictions.

### Prescribing rights

More controversial than the administration of medicines is perhaps the issue of prescribing rights. Currently, nurse practitioners are entitled to prescribing rights in the states and territories, although these vary in degree (see the table below), but there have been calls for all nurses to be given these rights in certain circumstances. The final report of the Victorian Nurse Practitioner project<sup>105</sup> argues that granting prescribing rights to nurse practitioners has improved patient care. In addition, it has fostered relationships between patients and nurses and within the health delivery team. As a bonus, the project report considers nurse prescribing has the potential to reduce health costs.

There are a number of sources which support prescribing rights for nurse practitioners.<sup>106</sup> Further, the National Nursing and Nursing Education Taskforce suggests that some form of prescribing could be explored for use by registered nurses working in areas like chronic disease management, mental health or primary care

The idea of practice nurses gaining some form of independence in prescribing is unlikely to be supported by the Australian Medical Association (AMA) for similar reasons as those advanced by its counterpart in the United Kingdom and noted earlier in this paper – nurses do not have the necessary expertise to prescribe, and to grant them such rights would be detrimental to patient care.

Further, many doctors consider prescribing rights in the context of a debate about task substitution, which, in turn, they see as a threat to the medical profession. The AMA argues that research has indicated that when Australians are sick, they want to see a doctor, not a

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175(3), to be able to offer and administer vaccinations in accordance with their organisation's Drug Therapy Protocol and Health Management Protocol. See [http://www.acu.edu.au/\\_data/assets/pdf\\_file/0015/16323/Nurse\\_Immuniser\\_updated\\_Brochure\\_2007\\_ACU.pdf](http://www.acu.edu.au/_data/assets/pdf_file/0015/16323/Nurse_Immuniser_updated_Brochure_2007_ACU.pdf) accessed 15 June 2007.

104. Immunisation in Tasmania, op. cit.

105. Department of Human Services, *Victorian nurse practitioner. Final report of the taskforce*, December 1999, [http://www.health.vic.gov.au/\\_data/assets/pdf\\_file/0008/17639/nurse\\_practitioner\\_taskforce\\_report.pdf](http://www.health.vic.gov.au/_data/assets/pdf_file/0008/17639/nurse_practitioner_taskforce_report.pdf) accessed 15 June 2007.

106. M. McMillan and H. Bellchambers, 'Nurse prescribing: adding value to the consumer experience', *Australian Prescriber*, 30, 2007, <http://www.australianprescriber.com/magazine/30/1/2/3/> accessed 18 June 2007.

'lesser' professional.<sup>107</sup> It considers that task substitution produces 'a competitive regimen of overlapping clinical roles' and calls for reforms to the health system 'that synergise the different skills of doctors, nurses and other health professionals'.<sup>108</sup> The AMA cites government funding to assist general practitioners to employ practice nurses as an example noting:

General practitioners foresaw how this [practice nurse incentives] could help them meet the needs of their patients. The AMA lobbied for the program. Now it is GPs who are making sure that the program is effective, delivering good outcomes for patients at a modest cost for taxpayers.<sup>109</sup>

Numerous overseas studies have found that patients approve of, and readily accept task substitution and nurse prescribing. Nurse prescribing has been seen by some commentators as improving outcomes for patients by promoting 'people-centredness, quality of care and accountability'.<sup>110</sup> Additionally, it has been argued that not only does it increase the competency of nurses, but it also delivers benefits to primary care teams, fostering better communication and sharing of information.<sup>111</sup> Supplementary arguments are that nurse prescribing:

often leads to more timely interventions, hence preventing the exacerbation of symptoms, and usually provides easier supervision of chronic conditions and that nurse prescribing promotes the maximization of resources by making the best use of skill mix of the workforce. It also leads to less wastage as patients are seen and reviewed more regularly.<sup>112</sup>

The following diagram illustrates the various nurse prescribing/medicine initiating regimes in force in Australia.

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107. C. Yong, 'Task substitution: the view of the Australian Medical Association', *Medical Journal of Australia*, Volume 185, Number 1, [http://parlinfoweb.parl.net/parlinfo/view\\_document.aspx?ID=170386&TABLE=jrnart&TARGET=](http://parlinfoweb.parl.net/parlinfo/view_document.aspx?ID=170386&TABLE=jrnart&TARGET=) accessed 12 July 2007.

108. *ibid.*

109. *ibid.*

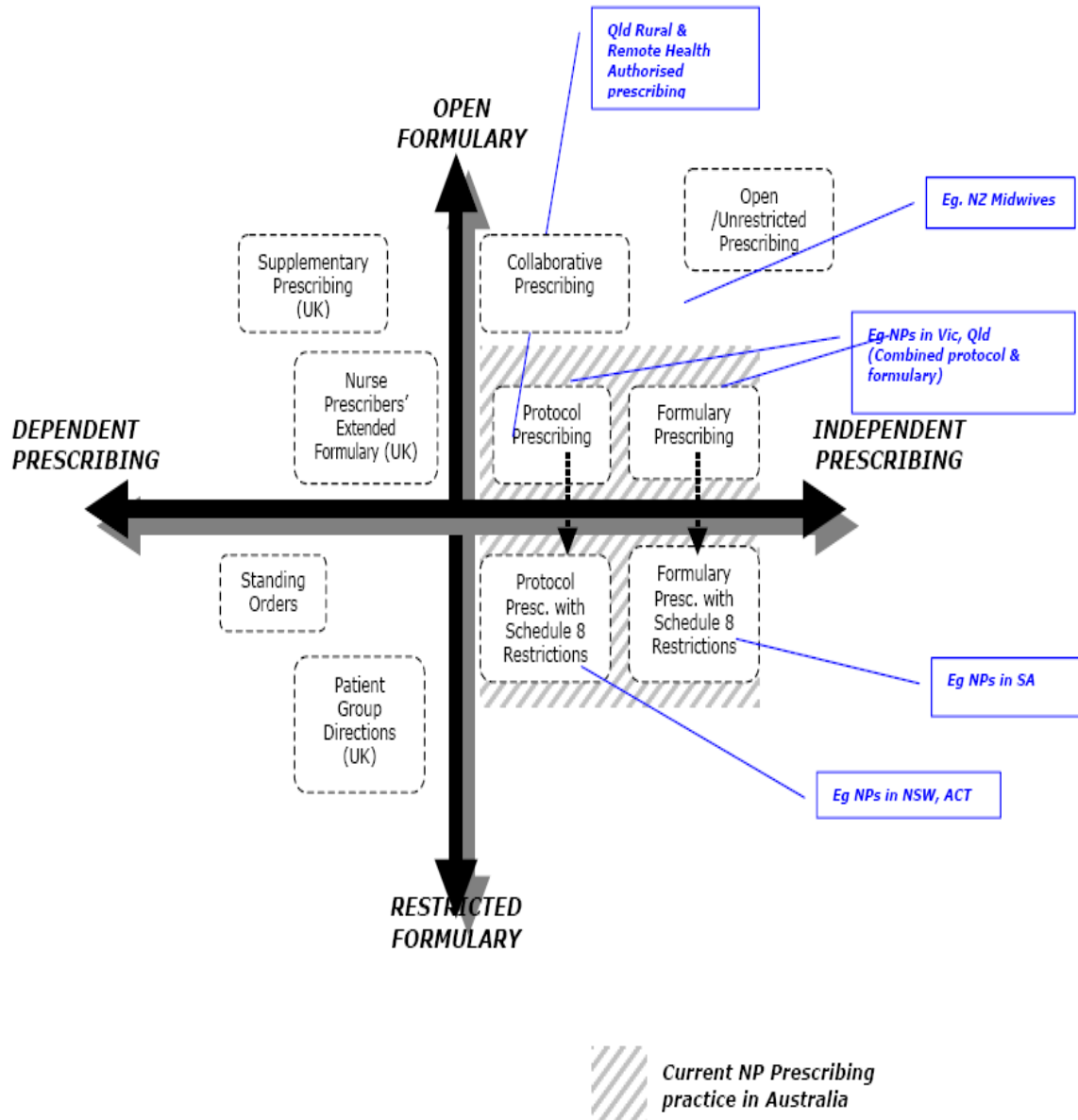
110. E. Fernvall Markstedt, Seventh Annual Meeting of the European Forum of National Nursing and Midwifery Associations and WHO, *A case history from Sweden*. Quoted in Department of Health and Children, *Consultation on the extension of prescriptive authority to nurses and midwives*, Dublin, 2006, [http://www.whc.ie/publications/Submissions\\_Nurse\\_Prescribing.pdf](http://www.whc.ie/publications/Submissions_Nurse_Prescribing.pdf) accessed 22 June 2007.

111. *ibid.*

112. K. Seager, 'Supplementary Prescribing', Bath and North Somerset Primary Care Trust, 2003. Quoted in Department of Health and Children, Dublin, *op. cit.*



## Nurse prescribing model



Source: The National Nursing and Nursing Education Taskforce<sup>113</sup> (See Appendix A for explanation of prescribing terminology)

113. Australian Health Ministers' Advisory Council, The National Nursing and Nursing Education Taskforce, *Nurse practitioners in Australia*, November 2005  
[http://www.dhhs.tas.gov.au/agency/pro/nursepractitioner/documents/may06/Reports%20for%20Hyperlink/Nurse Practitioner Mapping Nov2005.pdf](http://www.dhhs.tas.gov.au/agency/pro/nursepractitioner/documents/may06/Reports%20for%20Hyperlink/Nurse%20Practitioner%20Mapping%20Nov2005.pdf) accessed 18 September 2007

Despite this type of evidence and while it is supportive of practice nursing, the AMA does not share a view which has been recently advanced by the Productivity Commission that there is a potential to improve health outcomes by reconsidering what are appropriate mixes of competencies and by job redesign and substitution.<sup>114</sup>

The AMA argues that such proposals will not achieve efficiencies and may potentially affect safety and levels of care. It argues instead for a team work approach to health care where the doctor continues to be the 'natural and appropriate leader of the team' and against what it calls 'a competitive regimen of overlapping clinical roles'.<sup>115</sup>

But this argument is not proven and it could in fact be accused of protecting traditional – professional boundaries. As the Productivity Commission has suggested and what others have more enthusiastically advocated, is that health workforce planning should be more flexible. It should not simply be concerned with planning for numbers of a specific type of practitioner; it should instead focus on planning the mix of skills to provide adequate health services.<sup>116</sup>

#### Indemnity

It appears that general practitioner concerns about medical indemnity may have delayed the development of practice nursing in Australia. Watts et al argue that general practitioners were initially fearful 'about the legal consequences of actions and professional indemnity [and this overshadowed] their consideration of the contribution nurses can make to general practice health care'.<sup>117</sup>

In 2006, in an assessment of medical indemnity, the Medical Indemnity Policy Review Panel also considered the introduction of practice nurse Medicare items had brought uncertainty into medical indemnity coverage for doctors and medical practices. The Panel recommended that investigation of the issue was undertaken to find solutions.<sup>118</sup>

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114. Productivity Commission, *Australia's Health Workforce*, 2005, p.14, <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf> accessed 15 June 2007.

115. C. Yong, 'Task substitution: the view of the Australian Medical Association', *Medical Journal of Australia*, 185, 3 July 2006, <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf> accessed 15 June 2007.

116. S. Duckett, 'Health workforce design for the 21<sup>st</sup> century', *Australian Health Review*, 29 May 2005. <http://parlinfoweb.parl.net/parlinfo/Repository1/Library/Jnart/STHG60.pdf> accessed 20 June 2007.

117. Watts et al., op. cit.

118. Medical Indemnity Policy Review Panel, *Achieving stability and premium affordability in the Australian medical indemnity marketplace*, 2006,

Since that time, guidelines have been produced which describe the various responsibilities of employers and employees. The RCNA guide to nursing in general practice for example notes that if a patient is harmed as a result of negligence or omission by a practice nurse in a general practice setting, legal responsibility depends on whether the nurse is an employee of a practice or an independent contractor.<sup>119</sup>

If a nurse is an employee, the employer is legally liable. It is possible, however, for an employer to seek to recover costs or for patients to sue both the nurse and the employer. On the other hand, a nurse contractor bears responsibility for negligence, but an employer could also face legal proceedings if it could be proven that the nurse's negligence was the result of a general practitioner's negligence.

The RCNA guide stresses that it is critical in addressing indemnity concerns that practice nurses and general practitioners identify, agree upon and monitor the issues that govern the rights, roles and responsibilities of nurses in particular practice settings. Nurses and general practitioners should have a shared and accurate understanding of the scope and availability of insurance coverage and the extent to which it provides appropriate protection for the nurse.<sup>120</sup>

The RCNA guide warns that:

Under no circumstances should either a general practitioner or nurse working in general practice assume that everybody and everything will inevitably be covered under the "usual" insurance arrangements that predated the introduction of the nurse into the practice.<sup>121</sup>

It appears the issue of medical indemnity has been resolved for the time being by the provision of advice such as that provided by the RCNA. If prescribing rights for nurses in general practice were to be extended in the future, however, it is likely that similar concerns about what the individual liabilities of general practitioners and practice nurses may resurface.

## Culture

In recent times there has been considerable promotion of the concept of a health 'team' in general practice and an accompanying acknowledgment of the valued roles nurses, (and allied health workers), play in such teams. But at the same time, there continues to be discussion about whether general practitioners have abandoned long-standing notions that

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[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/B559308AE5A98B97CA25728700796361/\\$File/MI%20Policy%20Review%20Panel%20Report%20FINAL.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/B559308AE5A98B97CA25728700796361/$File/MI%20Policy%20Review%20Panel%20Report%20FINAL.pdf) accessed 22 June 2007.

119. Nursing in general practice, op. cit.

120. *ibid.*

121. *ibid.*

nurses should be subservient to doctors and that the role of nurses is that of 'hand maiden' to doctors, rather than cooperative professionals, 'on an equal footing with doctors in some areas'.<sup>122</sup> The fact that general practitioners are generally in an employer/employee relationship with practice nurses, may possibly exacerbate or perpetuate perceived or actual historical antagonisms.

If such a cultural situation is indeed the case, moves towards a more collaborative model of general practice teams in which nursing is seen as a profession complementary to medicine, not primarily subservient to it, will necessarily involve shifts in values, beliefs and attitudes that may linger in the general practice environment.

The fact that so many general practitioners now employ practice nurses indicates that practice nursing is increasingly valued by the medical profession and that if remnants of the hand maiden perception persist, they are being challenged. A report in *Australian Medicine* indicates also that the medical profession has embraced the concept of general practice teams and health professionals working together cooperatively.<sup>123</sup>

At the same time however, it can be argued that practice nursing can not enjoy the success it has experienced in the United Kingdom and New Zealand unless a more sophisticated general practice team environment is nurtured into the future. While consumers see nurses and general practitioners as a team,<sup>124</sup> it appears that this perception needs to become more obvious to the professions themselves. At present there are limited opportunities available for nurses and general practitioners to learn to work together. These need to be explored and ways found to incorporate stronger cooperative experiences into all stages of training for doctors and nurses and into professional interactions.

It may be argued also (as noted earlier in this paper) that the current notions of teams as solely general practitioner centric may need to be re evaluated in light of an increased emphasis on health prevention and chronic disease management.<sup>125</sup>

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122. L. Fagin and A. Garelick, 'The doctor–nurse relationship', *Advances in Psychiatric Treatment*, Volume 10, 2004, <http://apt.rcpsych.org/cgi/reprint/10/4/277.pdf> accessed 11 July 2007.

123. 'GPs the key to preventative care', *Australian Medicine*, Volume 19, Number 8, May, 2007.

124. J. Cheek, K. Price, A. Dawson, K. Mott, J. Beilby and D. Wilkinson, *Consumer Perceptions of Nursing and Nurses in General Practice*, Report to Commonwealth Department of Health and Ageing, Adelaide: Centre for Research into Nursing and Health Care, 2002 in Watts et al., op. cit.

125. This general practitioner centric approach surfaces in the RACGP paper, 'GPs and general practice team', (Draft position paper) at <http://www.racgp.org.au/Content/NavigationMenu/Advocacy/IssuesinGeneralPractice/GPworkforceandfundingissues1/Teamsinourgeneralpractices/20060829GPTeams.pdf> accessed 11 July 2007.

## Funding

A related issue to professional recognition is that of funding for general practice nursing services under Medicare. It can be argued that the effectiveness of general practice nurses is impeded by the current Medicare payment system under which nursing duties do not attract a payment unless through a fee-for-service system. The RACGP/RCNA Report notes that the health professions consider the current system hinders the adoption of a more collaborative approach because it devalues the nursing role.<sup>126</sup> Under the current funding regime, activities which nurses routinely perform without review by a doctor in other health care settings must be reviewed by a general practitioner to obtain a payment in the general practice setting. The RACGP/RCNA Report concludes that these types of arrangements need to be reviewed and reconsidered if general practice nursing is to be sustainable in the long term.<sup>127</sup>

## Conclusion

Health workforce shortages persist in Australia. These shortages, combined with an ageing population and a greater incidence of chronic disease, have meant that there is an increasing need to rethink ways in which health care in general practice can be delivered more effectively and efficiently.

One response to the current situation, improving the capacity of general practice to respond to the changing health environment by making more use of the services of nurses, has only recently been seriously promoted. International studies have indicated that better use of the services of nurses can bring a number of benefits to general practice. These include: improved health outcomes in chronic disease, assistance in primary-acute care integration, better coordination of care, increased workforce capacity, the provision of practical and professional support to general practitioners and enhancement in the range of services available to people attending general practice.

Review of research into the substitutability of nurses for doctors has also suggested that nurses could assume up to 70 per cent of the work currently undertaken by doctors and that this could enhance the quality of primary care services.

In 2005, approximately 58 per cent of Australian general practices employed practice nurses.<sup>128</sup> A number of initiatives have been put in place to help raise this figure. These initiatives have involved providing education and information to general practitioners about the benefits of employing practice nurses. They have also involved providing assistance to nurses to encourage them to regard practice nursing as a legitimate profession and to assist them to develop and maintain specific practice nursing skills.

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126. Watts et al., *op. cit.*

127. *ibid.*

128. ADGP, 2006, *op. cit.*

These strategies will help to develop practice nursing as one of a number of viable solutions which could be employed in the future as a broader range of patient services is increasingly needed. Nurses in general practice are likely to be called on increasingly to undertake a greater range of functions in general practice which may contribute to the delivery of better quality and safer patient care.

But there remain obstacles to be overcome if practice nursing is to fulfil its promise. These include addressing regulatory and other barriers which may either discourage general practitioners to employ practice nurses or may prevent practice nurses from fulfilling their potential as health professionals. These are undoubtedly vexing issues which have consistently raised concerns about appropriate roles and debates about the merits of task substitution within the important context of improving patient care and responding to a changing health environment.

These issues in turn are tied to a more fundamental issue: How governments can work more productively with the health professions to find ways to improve the capabilities of the health system to respond to changing environments and workforce needs. This clearly involves strategic, long-term workforce planning. This planning needs to ensure that the overall supply of medical practitioners and nurses is adequate, not only to meet the general needs of the population, but also that these practitioners are trained to meet the specific needs of an ageing population. There is likely to be little benefit in increasing the numbers of practice nurses for example if this simply exacerbates nursing shortages elsewhere.

It is essential that government plays a central role in this planning by introducing, maintaining and coordinating short and longer term strategies that balance patient and workforce needs. Introducing strategies to encourage nurses employed in administrative roles to return to practice nursing, for example, may produce short term workforce gains, but this type of policy alone will not address longer term workforce needs. Longer term strategies need to build on current policies which have begun to enhance the profile of practice nursing and to provide better support for specific practice nursing education. Similarly, these strategies will not ultimately succeed unless they are part of broader plan to increase nursing and general practitioner numbers to accommodate the changed work patterns and expectations of health workers.

Consequently, it is equally essential that both the medical and nursing professions contribute to a continuing planning process, that government encourages this participation and that the professions abandon traditional ideas about role models and attitudes. Greater strategic government involvement may encourage conscious review of any antagonistic cultural ideas about the role and contribution nurses can, and should make in the future general practice environment. This involvement may help to resolve issues in relation to the funding of services nurses provide in general practice as well as promote more constructive and cooperative dialogue about seemingly contentious matters, such as limited prescribing rights.

At the same time, this constructive dialogue needs to be in the context of a comprehensive whole of government and stakeholder approach which seeks to transform the health system to

account for and accommodate changing demographics and health needs identified in this paper.

## Appendix A

### Notes/Definitons on nurse prescribing models:

Collaborative prescribing	<p>This model has been described in the literature in relation to pharmacy prescribing and includes services such as anticoagulation management services, aminoglycoside monitoring and home medication reviews/Management. (Finley, Rens HR. et al. 2002; Gilbert, Roughead et al. 2002) Also sometimes referred to as "semi- autonomous prescribing".</p> <p><i>"Explicit collaborative agreements are negotiated within each facility outlining who is delegating and receiving authority, and demonstration of competence. The group of patients may be defined by the pharmacist's expertise. The physician diagnoses and makes initial treatment decisions for the patient, and the pharmacist selects, initiates, monitors, modifies and continues or discontinues pharmacotherapy as appropriate to achieve the agreed patient outcomes. The physician and pharmacist share the risk and responsibility for the patient outcomes"</i> (Emmerton, Marriott et al. 2005).</p>
Dependent prescribing	<p>'Dependent' prescribing occurs where there is delegation of authority from an independent prescriber and involves restrictions on prescribing activities, via protocols or formularies, which describe or demarcate the scope of the prescriptive authority. In the case of NPs currently practising within Australia, the delegation of prescribing authority is made by the body that authorises the NP guidelines or formularies.</p>
Formulary prescribing	<p>Refers to the development of an agreed list of drugs that may be prescribed by an individual or group of prescribers. The particular details of the drugs "formulation" is generally included. The inclusion of other details such as dosage, indications, special precautions vary from formulary to formulary. The focus of this model of prescribing is on providing information to guide the selection and clinical use of medications by prescribers and is therefore more open than protocol prescribing.</p>
Independent prescribing	<p>This term applies to a prescriber who is legally permitted and qualified to prescribe and take the responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required. An independent prescriber is also responsible for his or her own prescribing decisions. (National Prescribing Centre NHS 2004)</p> <p>Midwives in New Zealand have prescribing rights within the Midwifery Scope of Practice. There is no defined list of drugs that a midwife may prescribe. Rather, midwives are entitled to prescribe any drugs which may be necessary for a woman and/or baby for whom the midwife is providing care <i>on her own responsibility</i>. This means that midwives may prescribe drugs in pregnancy, labour and birth and up to six weeks after the birth where the woman is having an uneventful experience and where there is no reason for consultation or referral to a specialist.</p> <p>Whilst New Zealand midwives have independent prescribing they may not prescribe drugs for women or babies for complications requiring specialist referral or for the treatment of other conditions. (New Zealand College of Midwives 1995)</p>
Nurse Prescribers' Extended Formulary	<p>A UK scheme that allows registered nurses and midwives to prescribe from a Nurse Prescribers' Extended Formulary (NPEF) however the "medical conditions" that the prescribing encompasses are limited. There are conditions that need to be met before a nurse may be eligible for prescribing including completion of specified training, minimum post registration experience and support from employer. The nurse/midwives registration is annotated to indicate they are an approved NPEF prescriber.</p>
Open prescribing:	<p>Generally refers to unrestricted prescribing as in the prescribing range of medical practitioners.</p>
Patient Group Direction	<p>A United Kingdom (UK) model for designated NHS bodies. It allows for the supply and/or administration of "prescription only" medications by certain health professionals for groups of patients previously not identified prior to treatment without the need for an individual prescription (eg immunisations, screening programs, within prison/police services, emergency and/or mass treatment). In the UK this is not considered "prescribing" but has included in this model. (NHS Modernisation Agency 2005)</p>
Protocol prescribing	<p>Occurs when agreed protocols are developed to guide the pharmacological management and treatment of a condition, disease or injury based on the</p>



evidence for improving health outcomes. This is more restrictive/directive than formulary prescribing as the protocol defines the scope of prescribing practice.

Standing orders	The conditions, authorisations and requirements in relation to standing orders may differ from place to place however it generally refers to a process to allow "non prescribers" to administer or commence treatment/therapies such as medications without written or verbal authorisation of a prescriber for an individual.
Supplementary prescribing	A United Kingdom (UK) model that involves a "voluntary partnership between the independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement" (NHS Modernisation Agency 2005). There is no formulary used in supplementary prescribing and supplementary prescribing is not restricted to one-to-one prescriber partnerships. The independent prescribers are generally doctors or dentists and supplementary prescribers are pharmacists or nurses. The roles are well defined and the lines of accountability are clear with the independent prescriber undertaking the initial assessment, diagnosis and treatment plan. The supplementary prescriber can then write prescriptions within the scope of the management plan, monitor and record outcomes and adjust medications (referring to the independent prescriber where appropriate).

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