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COMMENTARY

Transforming health care delivery: The role of primary health care nurses in rural and remote Australia

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Abstract

Aim: This paper describes the policy context and approaches taken to improve access to primary health care in Australia by supporting nurses to deliver improved integrated care meeting community needs.

Context: In Primary Health Care (PHC), the nursing workforce are predominantly employed in the general practice sector. Despite evidence that nurse-led models of care can bridge traditional treatment silos in the provision of specialised and coordinated care, PHC nurses' scope of practice varies dramatically. Nurse-led models of care are imperative for rural and remote populations that experience workforce shortages and barriers to accessing health care. Existing barriers include policy constraints, limited organisational structures, education and financing models.

Approach: The Australian Primary Health Care Nurses Association (APNA) received funding to implement nurse-led clinics as demonstration projects. The clinics enable PHC nurses to work to their full scope of practice, improve continuity of care and increase access to health care in under serviced locations. We reviewed a range of peer-reviewed literature, policy documents, grey literature and APNA provided sources, particularly those relevant to rural and remote populations. We argue more focus is needed on how to address variations in the scope of practice of the rural and remote PHC nursing workforce.

Conclusion: Despite growing evidence for the effectiveness of nurse-led models of care, significant policy and financial barriers continue to inhibit PHC nurses working to their full scope of practice. If their potential to transform health care and increase access to health services is to be realised these barriers must be addressed.

KEYWORDS

community based service delivery, health policy, primary health care development, rural workforce issues, workforce planning

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1 | INTRODUCTION

Recent reforms in health policy in Australia have supported a range of strategies designed to improve the delivery of primary health care (PHC).[1] A focus on PHC is essential to achieving universal health coverage and improving the wider determinants of health and has been described as 'the foundation of a highly functioning health care system'.[2,3] In Australia, the nursing workforce in PHC are mostly employed in the general practice sector and are the only health profession with a greater number working in remote and very remote locations relative to the population in these areas.[4]

However, the extent to which PHC nurses' scope of practice is fully utilised varies dramatically. The Australian Primary Health Care Nurses Association (APNA) conducted a workforce survey in 2022 that found one third (32%) of all primary health care nurses reported that their skills are not utilised often or most of the time.[5] This is despite agreement in the literature that transforming nursing practice in PHC settings has the potential to address the unmet health care needs of individuals, families and communities.[6] In fact, nurse-led services have been described as 'the sleeping giant of health care reform in Australia' in terms of their potential to transform health service delivery.[7] This statement has important implications for many underserved rural and remote communities.[3] Our commentary highlights strategies undertaken by APNA to support the role of PHC nurses in contributing to more effective and accessible service delivery models in rural Australia, including nurse-led clinics (NLCs).[8,9]

The policy context that informs the development of nurse-led models of care is described, including an identification of the enablers and barriers that inhibit PHC nurses working to their full scope of practice. Lessons learnt that can help to inform approaches to building the capacity of the rural and remote PHC workforce are outlined.

2 | WHY THIS MATTERS

A newly released scoping review synthesised both Australian and international literature to develop a robust and contemporary definition for Nurse-led clinics.[10] 'Nurse-led clinics offer nurse-led care provided within a formalised framework of heterogeneous components constituted through government legislation, regulatory bodies, health care policy, funding models, health care systems, or the setting in which nurses act. Further, nurse-led clinics may be informed by and evolve in response to the needs of health care consumers, community or lobby groups, key health conditions within a community, broader population needs or other health professionals'.[10]

Nurse-led models of care can bridge traditional treatment silos in the provision of specialised and coordinated care and address previous gaps in health care service delivery and policy constraints. A lack of organisational structures, education and financing models are all significant barriers that inhibit nurses working to their full scope of practice in PHC.[6,10] A recent narrative review found low awareness and ambiguity among health services and within communities about models of care led by nurse practitioners in rural areas.[11] There is an urgent need, therefore, to build the evidence base for nurse-led PHC models and the ways in which they can impact on primary health service delivery in rural and remote Australia.

3 | EVIDENCE FOR NURSE-LED CLINICS AND MODELS OF CARE

Nurse-led clinics are an alternative team-based model of service delivery. They are not a new concept and operate in many settings from acute care to primary health care, both nationally and internationally.[12] Evidence for their positive impact on patient outcomes, patient satisfaction and access to care have been widely reported for some time.[13,14] NLCs have been shown to improve communication with patients[15] and nurses working in clinics report higher levels of job satisfaction.[12] The COVID-19 pandemic resulted in a rapid-uptake of nurse-led telehealth services in many regions globally with evidence of increased access to health care, the provision of continuous and patient-centred care and increased satisfaction among patients and nurses.[16] Australian PHC nurses reported variable experiences of utilising telehealth where familiarity with the technology and availability of appropriate technology impacted on the capacity to ensure safe and effective PHC during the pandemic.[17] In rural and remote areas that experience workforce shortages and limited access to health care services, NLCs offer people improved opportunities to access health care, treatment and advice.[12] Furthermore, nursing skills are highly suited to activities such as health education, health promotion, illness prevention and the implementation of behaviour change strategies, all of which are recognised requirements for the management of chronic disease.[18] The literature confirms both the feasibility of NLCs and their role in supporting improved patient outcomes but there is scant information on how to initiate, resource and run a successful clinic.[7]

4 | POLICY CONTEXT

Health care rights in Australia include access to safe and high-quality health care services and treatment that

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maintains a person's dignity and respect.[19] The National Health Reform Agreement between the states and the Commonwealth identified PHC as a vital component in developing a comprehensive health care system in Australia.[20] In 2013, the first National Primary Health Care Strategic Framework was endorsed by federal and state governments as a mechanism for more coordinated action in service delivery.[21] The framework acknowledged that rural and remote services differ from their metropolitan equivalents and engagement with communities and Medicare Locals are needed to identify service gaps and strategies to fill those gaps.[21] The framework also identified the recruitment and orientation of nurses to general practice as an important goal for coordinating and transforming the PHC sector.[21]

In 2012, the Commonwealth provided funding to support the employment of general practice nurses and their work at an expanded scope of practice.[22] Under the Advancing Nurse Clinics in General Practice program from 2013 to 2014, nine Medicare Locals were funded to conduct demonstration projects in nurse clinics within general practices.[8] The demonstration projects were in collaboration with the general practice team, consumers and peak health organisations to address evidence based, locally identified health needs.[8] In 2014 to 2015, APNA took over these clinics as part of the Nursing in General Practice Program following the conclusion of the Australian Medical Local Alliance.[8] More recently, APNA received funding from the Australian Government to deliver the Nursing in Primary Health Care (NiPHC) Program. Eleven clinics were recruited in the first round of the program from 2015 to 2018, and 57 clinics were recruited in the second round between 2018 and 2023. The NiPHC strategy aims to improve team-based approaches to PHC service delivery through nurse delivered (team based) models of care (https://nurseclinics.apna.asn.au/real-nurse-clinics/). This innovative use of the nursing workforce is consistent with the Commonwealth's program of PHC reform that aims to promote primary care teams where all members are supported to fully develop their clinical skills and potential.[21]

5 | WHAT IS NEEDED?

Understanding how NLC models of care operate is crucial to strengthening PHC but there is great variability and no agreement on key metrics or the critical elements that contribute to a clinic's success.[7] To support the expansion of NLCs, more evidence from multiple clinics is needed but this is challenging when there are relatively few established clinics and no guidelines or standards that support the collection and application of the type of data required.[13] At present, PHC nurses are expected to persuade often sceptical colleagues about the value of NLCs, create a viable business plan and perform their duties as a nurse. This highlights how a range of expertise is needed to support nurses and successfully initiate and coordinate NLCs. A clearer picture of the processes, problems and people involved in sustaining NLCs in rural Australia is needed, including an understanding of the motivations and incentives of all those involved. As the peak body for consolidating current knowledge about NLCs, APNA is ideally placed to ensure information about setting up and sustaining clinics is compiled and disseminated across Australia.

6 | RESOURCES DEVELOPED BY APNA

Over the past 5 years, APNA has developed a range of resources to support demonstration projects in NLCs. This includes a building block implementation framework that identifies eight building blocks that support PHC nurses in planning and considering where, how and when clinics will operate.[23] The framework also includes information on developing connections with stakeholders, patient engagement and guidance on how to implement a rigorous approach to quality and evaluation, which is important to provide a robust evidence base about NLCs.[23]

In addition to the building blocks implementation framework, nurses are provided with comprehensive support throughout the program including tailored introductory workshops, online community of practice meetings supported by an asynchronous digital community of practice website, access to APNA online learning modules and individualised coaching and support from the APNA Building Nurse Capacity program team.[9] Grant funding is provided to participating organisations to assist with establishment costs for the clinics and to support backfill for nurses to attend to project management activities (e.g. protected time for completion of quality improvement activities or attendance at project related workshops).[9] The NLCs project has a strong focus on developing sustainable and replicable clinic models that will continue to operate beyond the end of the project period and education and resources have been developed for nurses on the barriers and enablers to clinic financial viability.[9]

7 | LESSONS LEARNED

In Australia, there are few financial incentives for nurses to increase their scope of practice in PHC as nurse practitioners are currently the only nurses who can prescribe medications or receive Medicare reimbursements.[11] There

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are too few nurse practitioners and in the PHC sector nurses (especially those working in general practice) currently work under an award that pays them significantly less than hospital nurses.[24] Other challenges to providing comprehensive PHC to people with high levels of chronic disease include models of care that focus on single-disease-specific management, where service users are required to attend multiple providers. Likewise, clinical guidelines predominantly focus on a single disease, potentially contributing to conflicting medication and care management for people with multimorbidity.[25] Innovative strategies are required to reduce care fragmentation for people with multimorbidity.[1,7,25]

8 | CONCLUSION

Governments and the nursing profession have sought to implement new models of nurse-led primary health care and initiatives that enable and expand nurses' scope of practice to include independent practice and prescribing, and transition from specialist to generalist roles. However, as the burden of chronic disease grows globally the need to improve access to PHC services becomes more urgent. Although NLCs exist in a multitude of health care settings there is no standardised model with marked variation in the way that different clinics are structured. Nevertheless, there is growing evidence for their effectiveness in providing a range of positive and coordinated health care outcomes.

CONTRIBUTORS AND SOURCES

This commentary forms part of a collaboration between the Australian Primary Health Care Nurses Association and Associate Professor Rachel Rossiter and Dr Tracy Robinson who have extensive experience in primary health care and rural and remote nursing. They reviewed literature, generated and critically reviewed drafts and Rachel provided oversight of the team. Linda Govan has a background in primary health nursing, health administration and public health. In her current role, she focuses on building the capacity of the primary health care nursing workforce and exploring opportunities within the primary health care reform space in Australia. Linda provided information and historical context related to this work and reviewed all drafts. Cressida Bradley also has a nursing background and diverse experience across a range of sectors including health care, tertiary education and private enterprise. Her expertise includes data, evaluation and biostatistics. Cressida provided information and reviewed all drafts of the work.

AUTHOR CONTRIBUTIONS

Tracy Robinson: Writing – original draft; investigation; writing – review and editing. **Linda Govan:** Writing – review and editing; resources. **Cressida Bradley:** Writing – review and editing; resources. **Rachel Rossiter:** Conceptualization; writing – review and editing; project administration.

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CONFLICT OF INTEREST STATEMENT

None.

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