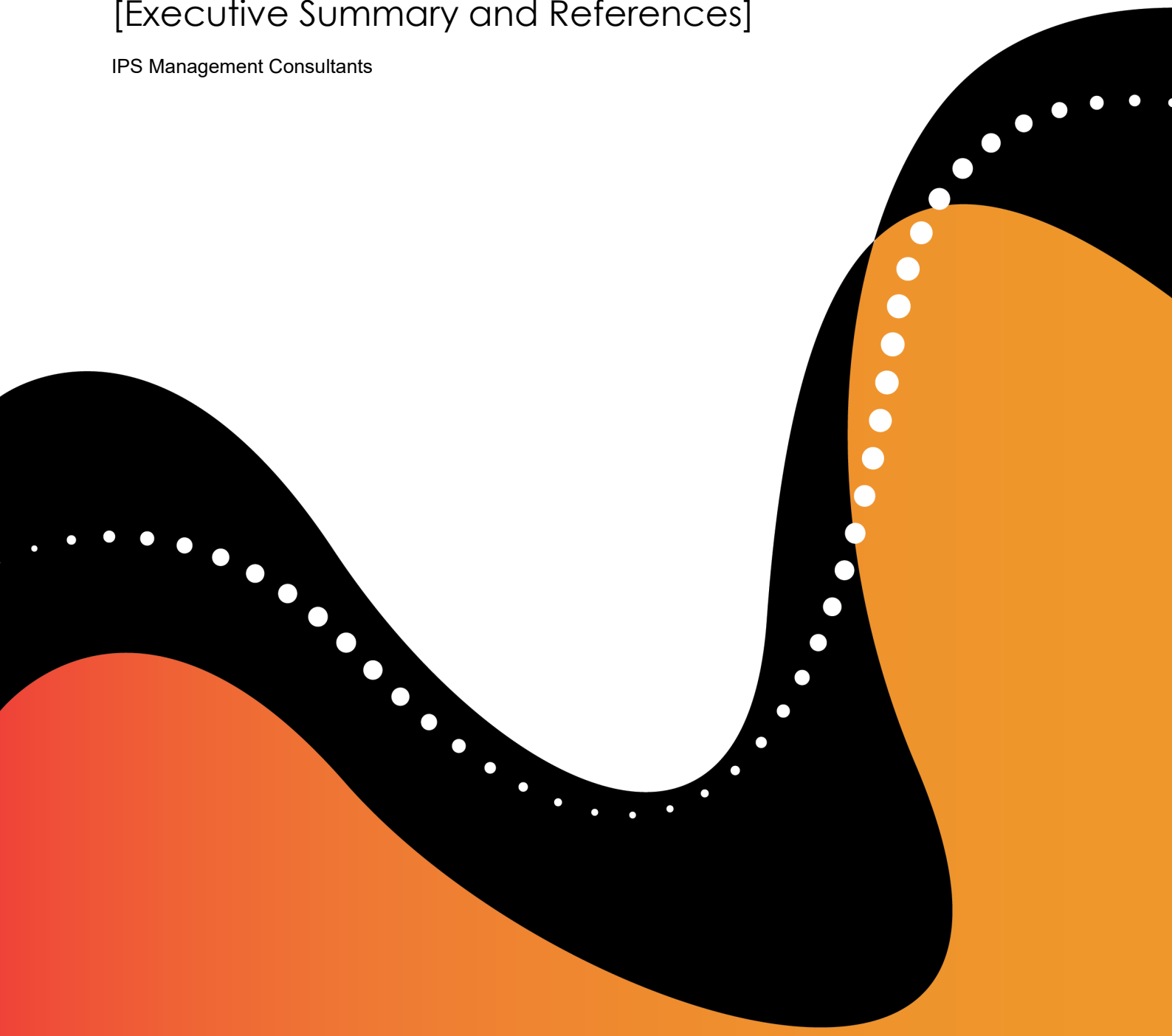


# Independent review of collaborative arrangements

2023 Report Extract

[Executive Summary and References]

IPS Management Consultants



## **Acknowledgement**

*We acknowledge the Traditional Owners and Custodians of Country throughout Australia and acknowledge their continuing connection to land, water and community. We pay our respects to the people, the cultures and the Elders past and present.*



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IPS is a Supply Nation certified, majority First Nations-owned company providing innovative and focused consulting services in Research and Evaluation, First Nations Advisory, Organisational Capability and Business Advisory.

**Note: This report incorporates stakeholder views to offer contextual insights and real-world discussions on collaborative arrangements. Whenever stakeholder views are presented, the respective stakeholder group will be explicitly identified. It is important to note that in certain cases, stakeholder views may not necessarily align with factual accuracy.**

## Terminology

Term	Definition
Culturally and linguistically diverse	People who were born in non-English speaking countries and/or people who do not speak English at home.
First Nations people	Aboriginal and Torres Strait Islander people.
Low socio-economic background	The social and economic position of a given individual is low when the household's disposable income (after paying tax) is below a level considered adequate to achieve and acceptable standard of living.
Medical Practitioner	The terms Medical Practitioner, Medical Doctor and General Practitioner have been used interchangeably.
Medicare Benefits Scheme (MBS)	Medicare is a national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The MBS is the listing of Medicare services subsidised by the Australian Government.
Nurse Practitioner	A nurse practitioner is a registered nurse endorsed as a nurse practitioner by the NMBA. The nurse practitioner practices at an advanced level, meets and complies with the nurse practitioner standards for practice, has direct clinical contact and practices within their scope under the legislatively protected title 'nurse practitioner' under the National Law.
Older person	A person aged 65 years and older.
Participating Midwife	A Participating Midwife is a Registered Midwife with endorsement for Scheduled Medicines who provides autonomous and collaborative midwifery care.
Primary health care	Whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment. (WHO and UNICEF. <i>A vision for primary health care in the 21st century: Towards UHC and the SDGs.</i> )
Tertiary health care	Tertiary health care refers to highly specialised consultative medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples include bypass, renal, plastic surgery.
Therapeutic Goods Administration	The Therapeutic Goods Administration is the medicine and therapeutic regulatory agency of the Australian Government.

## Glossary

Acronym	Expanded form
ACNP	Australian College of Nurse Practitioners
AMA	Australian Medical Association
MBS	Medicare Benefits Scheme
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
RACGP	Royal Australian College of General Practitioners
SDG	Sustainable Development Goals
TGA	Therapeutic Goods Administration
UHC	Universal Health Coverage
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

# Executive Summary



## Introduction

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Collaborative arrangements were introduced in 2010 through the National Health (Collaborative arrangements for midwives) Determination 2010 and National Health (Collaborative arrangements for nurse practitioners) Determination 2010 under the *National Health Act 1953*. They were introduced as a prerequisite to a Nurse Practitioner and Participating Midwife providing health care services subsidised by the Medicare Benefits Schedule (MBS) and to prescribe certain medications on the Pharmaceutical Benefits Scheme (PBS). This was a Ministerial determination made at the time of the legislative amendments (Health Insurance Amendment Regulations 2010) to allow eligible patients access to rebates through the MBS services for eligible Nurse Practitioners and Participating Midwives.

To ensure Medicare and the MBS align to contemporary and clinical evidence and practice and improve health outcomes, the Government established the MBS Review Taskforce (Taskforce) to provide recommendations to the Minister to ensure the MBS is affordable with universal access, is best practice health service, value for the individual patient and value for the health system.

To inform a review of the MBS, the Participating Midwives Reference Group and the Nurse Practitioner Reference Group conducted a review and provided reports to the Taskforce highlighting issues and providing recommendations that aligned to the Taskforce's objectives. It was noted that despite the overwhelming consensus of the importance of clinical collaboration in the health care space, collaborative arrangements have become increasingly debated in more recent years and both the Participating Midwives Reference Group and the Nurse Practitioner Reference Group recommended removal of the legislated requirement for collaborative arrangements.

The recommendation was not endorsed by the Taskforce, instead they recommended a review into the efficacy and appropriateness of collaborative arrangements be undertaken. IPS was engaged by the Australian Department of Health and Aged Care (the department) to conduct the review.

## Aims of this review

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This report represents the independent review of collaborative arrangements. The scope of the review involved the collection, synthesis and summary of national and international data relating to collaborative arrangements between Specialists, General Practitioners, other Medical Practitioners, Nurse Practitioners and Participating Midwives. In addition to Australian and international research and literature, the review considered the views and experiences of stakeholders across the country.

## Methodological overview

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The review utilised a mixed methods approach, combining elements of qualitative and quantitative research to obtain a broad and deep understanding of collaborative arrangements. Six areas of focus were provided by the department to guide the review:

- An examination of Nurse Practitioners' background and context in the healthcare system.
- An examination of Participating Midwives' background and context in the healthcare system.
- Collaborative Arrangement Models used in Australia and comparisons with international models.
- The impact of collaborative arrangements on patients.
- The administration elements of collaborative arrangements for Medical Practitioners, Nurse Practitioners and Participating Midwives.

- Impact of collaborative arrangements, or their absence, on funders and the impact on systems of removing collaborative arrangements.

The areas of focus were by literature and stakeholder engagement which included interviews with representatives from 7 of 9 Overarching Organisations, 3 of 3 Nurse Practitioner Organisations, 5 of 5 Midwives' Organisations, 8 of 8 Medical Organisations. Also, Nurse Practitioners, Participating Midwives and Medical Practitioners were invited to participate in an online survey.

## Fieldwork

Field work was conducted over a five-week period from the 1st June 2022 to the 6th July 2022. Stakeholders were engaged for interview remotely by phone or by video conference. The online survey was live from the 4th June 2022 to 6th July 2022.

## Summary of engagement

Interviews: of the 21 organisations and colleges invited to participate by the department, 19 accepted and 2 declined to participate in engagements. Of the 19 organisations that participated, representatives were selected by the organisation to represent their views and, on some occasions, more than one representative was interviewed at their request. A total of 32 interviews were conducted with representatives from Overarching Organisation, Nurse Practitioner Organisation, Midwives' Organisations and Medical Organisations.

Survey: a total of 598 responses were captured for the survey, 496 respondents completed the survey in full and 102 respondents completed part of the survey. In most instances of partial responses, respondents completed half to three quarters of the survey and responses were included in the analysis. Nurse Practitioners represent the majority of responses (55%) with Medical Doctors at 19% and Participating Midwives 17%.

## Limitations

- This project was limited by the availability of stakeholders due to the Covid-19 pandemic. This was further exacerbated due to stakeholders being health professionals working within the health sector. In response to this, IPS offered stakeholders flexible time frames for engagement to overcome this barrier and ensure that all stakeholders had the opportunity to participate.
- While some key lines of enquiry sought documented cases or evidence, this was not available in the literature or provided by stakeholder organisations following requests.

## Out of scope

The following items were stipulated as out of scope for the review and have not been considered:

- The reform for Nurse Practitioner / Participating Midwife credentialing and training.
- The Medicare Benefits Schedule (MBS) Review Taskforce recommendations.
- Additional requirements outside current requirements.
- Provision of recommendations or suggested solutions.

## Findings

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All stakeholders held strong positions on collaborative arrangements and took the opportunity to voice their views during the interview. While some stakeholders had a good understanding of collaborative arrangements overall, it was also found that many discussed the lack of clarity within the legislation and subsequent approach to establishing collaborative arrangements.

An examination of Nurse Practitioners' background and context in the healthcare system found that Nurse Practitioners work in a range of settings such as the patient's home, health clinics, medical practices or the Nurse Practitioner's private consulting rooms (Australian Government, 2018). Nurse Practitioners were found to be effective in their roles and provide quality health services alleviating some of the pressures on the health care system today.

The literature revealed that Nurse Practitioners are trained to work across several areas within the health care system including emergency, aged care, chronic disease management, mental health, dementia, neonatal, sexual health, rural and remote and primary health care. Engagement and survey data found that Nurse Practitioners play an important role within the Australian Healthcare system and that working to their full scope of practice enables them to fill important gaps in the system. In particular, stakeholders felt the role was most beneficial within the tertiary healthcare system (hospitals) and in regional or remote areas.

In general, it was found that the role of Nurse Practitioner had gained greater respect and importance in the health care system but stakeholders held the view that there was still great opportunity to better embrace and utilise Nurse Practitioners' skills to better meet the needs of all Australians.

An examination of Participating Midwives' background and context in the healthcare system found that following a review of the role of midwives in 2009, reforms were legislated in the *Health Legislation Amendment Midwives and Nurse Practitioners Act 2010*. These reforms enabled Participating Midwives to prescribe certain PBS listed medications and enabled their patients to access Medicare rebates for services.

However, their involvement in collaborative arrangements has not been realised to the same degree as Nurse Practitioners. Since establishment, to overcome a low number of midwives entering into collaborative arrangements, the opportunity for a midwife to enter into a collaborative arrangement has expanded beyond a Medical Practitioner to also include arrangements with Hospitals following assessment and engagement with a Medical Practitioner.

Despite this change, National Health Workforce Dataset (2021) shows that there are 26,350 employed midwives and of those the Nursing and Midwifery Board of Australia (NMBA) state in the Registration Data Table (2021) 795 are Participating Midwives, only 3% of the workforce.

The review found that Participating Midwives are a critical part of the Australian healthcare system and are an essential choice of maternity care provider. Stakeholders felt that Participating Midwives effectively collaborate with obstetricians and General Practitioners and are instrumental to the continuity of care for women across the childbearing continuum and early transitions to parenting.

Collaborative Arrangement Models vary internationally and the literature review explores differences and similarities to the Australian approach. In Australia, the purpose of collaborative arrangements is to enable Nurse Practitioners and Participating Midwives to provide Medicare funded services and prescribe certain medications on the PBS. However, many stakeholders held the view that collaborative arrangements also involved clinical collaboration. Clinical collaboration is a critical part of health care and was found to occur regardless of a collaborative arrangement.

Collaborative Arrangements are formal arrangements (note that a written referral from a Medical Practitioner



meets this requirement). The National Health (Collaborative Arrangements for Midwives) Determination 2010 and the National Health (Collaborative arrangements for Nurse Practitioners) Determination 2010 state that a collaborative arrangement must provide details of consultations between Nurse Practitioners or Participating Midwives with the Medical Practitioner, referrals to Medical Practitioners and transfer of care to a Medical Practitioner.

The legislation details four types of collaborative arrangements: the Participating Midwife or Nurse Practitioner is engaged or employed by a Medical Practice; a patient is referred to the Participating Midwife or Nurse Practitioner by a Medical Practitioner; the Participating Midwife or Nurse Practitioner has a written collaborative agreement with a Medical Practitioner(s) covering one or more patients; the Participating Midwife or Nurse Practitioner has an individual collaborative arrangement with a Medical Practitioner(s) for a patient.

Engagements and survey data found that, in addition to the four types of collaborative arrangements as noted in the legislation, there are a number of additional collaborative arrangement models being used across the country and being referred to as a collaborative arrangement. Examples provided included arrangements in hospital settings, private practice and remote collaborative arrangements. It was also found that some Medical Practitioners had established collaborative arrangements with Nurse Practitioners through a verbal agreement.

In some contexts, collaborative arrangements were found to work well, such as in hospital settings where medical practitioners are readily available and are willing to enter into a collaborative arrangement with Nurse Practitioners. In other contexts, such as rural and remote areas, it was found that collaborative arrangements were harder to enter into due to the lack of available Medical Practitioners which impacts on the Nurse Practitioner's ability to offer MBS rebated services in rural and remote locations.

Engagement and survey data found that stakeholders held various views as to how a scope of practice related to a collaborative arrangement with many noting that collaborative arrangements don't, or shouldn't, relate to a Nurse Practitioner's or Participating Midwife's scope of practice. Nurse Practitioners and Participating Midwives scope of practice is determined by regulation through the NMBA, such as the Nurse practitioner Standards for Practice (2021), Midwife Standards for Practice (2018) and Endorsement for Scheduled Medicines for Midwives (2017).

The impact of collaborative arrangements on patients was found to have some positive impact but more generally, negative impacts. Positive impacts included the increased level of patient advocacy through engagement with a Nurse Practitioner or Participating Midwife, especially within First Nations people. Also, an increased level of confidence and trust for the patient when Nurse Practitioners, Participating Midwives and Medical Practitioners are working together to deliver continuity of care.

Negative impacts on patients were found where there was a lack of collaborative arrangements that led to limited access to care through increased cost and delayed care, MBS and PBS restrictions, poor communication between health practitioners and misalignment of scope between collaborating health practitioners. Stakeholders noted that the need for collaborative arrangements creates barriers to accessing private practice Nurse Practitioner and Participating Midwife services. This was exacerbated in regional and remote locations where a town may have a Nurse Practitioner or Participating Midwife but not a Medical Practitioner to provide the necessary referral for a patient to see them. The literature revealed that with the limitations surrounding access to Medical Practitioners in rural and remote settings, collaborative arrangements are considered an unnecessary limitation for Nurse Practitioners and Participating Midwives and the policies and regulations can weaken their positions as legitimate health care providers.

The literature revealed collaborative arrangements can have a negative impact on older patients, patients with a lower socio-economic status, those living rural and remote areas and First Nations people especially those living in remote and very remote areas. This was supported by engagements and survey data.

Most stakeholders held the view that the removal of collaborative arrangements would result in positive impacts on patient outcomes. Removal was thought to improve access to care and choice of health practitioner, it would enable Nurse Practitioners to provide care to patients without delays, it would potentially lead to a higher uptake of private midwifery models of care. This may improve relationships between health professionals.

The administration elements of collaborative arrangements for Medical Practitioners, Nurse Practitioners and Participating Midwives found that collaborative arrangements pose additional administrative barriers and burden, especially on the Nurse Practitioners and Participating Midwives. There is a legislative requirement for the Nurse Practitioner or Participating Midwife to obtain patient consent, which is necessary with or without collaborative arrangements, but some stakeholders noted it was more extensive and involved the preparation of additional documentation to access Medicare rebates.

Medical Practitioners reported positive impacts relating to administration that included the ability to distribute the workload and improve patient access to care. While negative impacts included Medical Practitioners' perceived responsibility for oversight of the Nurse Practitioner or Participating Midwife, increased liability and Medical Practitioners being involved in the provision of care but not being paid. Some organisations felt there was no impact at all, particularly if the collaborative arrangement was a remote agreement (i.e., one in which the collaborating health professionals are separated by geographical distance).

Impact of collaborative arrangements, or their absence, on funders and the impact on systems of removing collaborative arrangements was interesting. Most stakeholders (74% of survey participants and 72% of interview participants) felt that the removal of collaborative arrangements would be beneficial and would not lead to fragmentation of patient care. However, some survey respondents and interview participants also stated that it would be essential to ensure clinical collaboration continued and that legislation remained to keep current Medicare and PBS access in place.

Of the remaining 28% of interview participants, some Medical Practitioners and Overarching Organisations felt that removal of collaborative arrangements could result in fragmented care. However, the main reasoning was the assumption that removal of collaborative arrangements would lead to a reduction in clinical collaboration overall.

The table below provides a high-level summary of findings as presented above aligned to each key line of enquiry and associated page number in the report.

## Summary of findings

### Nurse practitioners (background)

Key line of enquiry	Finding
<p>Why was the role of the Nurse Practitioner established in Australia? (Informed by literature only)</p>	<p>The literature noted that Nurse Practitioner models were piloted in rural and remote areas in response to limited access to medical practitioners and an increased need for specialised nursing in 1990. Nurse Practitioners were found to be effective in their roles and provide quality health services alleviating some of the pressures on the health care system</p>
<p>How has the role of Nurse Practitioners evolved over time?</p>	<p><b>Finding 1</b></p> <p>The literature identified that initially each state had specific legislation for Nurse Practitioners including educational requirements, which limited the ability of Nurse Practitioners to travel and work around Australia. This was resolved in 2009 by the <i>Health Practitioner Regulation National Law Act 2009</i> which create a national registration and accreditations scheme for Nurse Practitioners.</p> <p>Further reforms were passed in 2010 to enable Nurse Practitioners to provide some services under the MBS and prescribe some medications under the PBS and in 2011 the NMBA introduced a registration standard for Nurse Practitioners. This was further updated in 2015.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that the role of Nurse Practitioner had gained greater respect and importance in the healthcare system today. The role of Nurse Practitioners has evolved considerably, especially when compared to that of Participating Midwives. Stakeholders held the view that there was still great opportunity to better embrace and utilise Nurse Practitioners and Participating Midwives to better meet the needs of all Australians.</p>
<p>What is the role of the Nurse Practitioner in the Australian Healthcare system today?</p>	<p><b>Finding 1:</b> The literature revealed that Nurse Practitioners are trained to work across several areas within the health care system including emergency, aged care, chronic disease management, mental health, dementia, neonatal, sexual health, rural and remote and primary health care.</p> <p><b>Finding 2:</b> Engagement and survey data found that Nurse Practitioners play an important role within the Australian Healthcare system and that their scope of practice enables them to fill important gaps in the system. In particular, stakeholders felt the role was most beneficial within the tertiary healthcare system (hospitals) and in regional and remote areas.</p>

## Participating Midwives (background)

Key line of enquiry	Finding
<p>Why was the role of the Participating Midwife established in Australia? (Informed by literature only)</p>	<p>The role of Participating Midwife was established to enable their patients to access Medicare rebates for services and to provide Participating Midwives with prescribing rights to certain PBS listed medications.</p>
<p>How has the role of a Participating Midwife evolved over time?</p>	<p>Since establishment, the opportunity for a midwife to enter into a collaborative arrangement has expanded beyond a Medical Practitioner to also include arrangements with Hospitals following assessment and engagement with a Medical Practitioner.</p>
<p>What is the role of the Participating Midwife the Australian Healthcare system today?</p>	<p><b>Finding 1</b></p> <p>National Health Workforce Dataset (2021) shows that there are 26,350 employed midwives and of those the NMBA state in the Registration Data Table (2021) 795 are Participating Midwives with scheduled medicines, only 3% of the workforce.</p> <p><b>Finding 2</b></p> <p>Engagements found that Participating Midwives are a critical part of the Australian healthcare system, are truly integrated into health care services and essential for private birthing. Stakeholders felt that Participating Midwives effectively collaborate with obstetricians and General Practitioners for advanced care support and are instrumental to the continuity of care for women through the antenatal, intrapartum and postpartum periods.</p>

## Collaborative arrangement models

Key line of enquiry	Finding
<p>What is the purpose of collaborative arrangements in Australia? Page 49</p>	<p><b>Finding 1</b></p> <p>The purpose of collaborative arrangements in Australia was to enable Nurse Practitioners and Participating Midwives to provide Medicare funded services and prescribing rights to certain medications on the PBS.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data revealed that collaborative arrangements were often thought to involve clinical collaboration, rather than (or as well as) being linked to MBS and PBS.</p>
<p>How many variations of collaborative arrangements are there in Australia? How do they differ?</p>	<p><b>Finding 1</b></p> <p>The types of collaborative arrangements for a Nurse Practitioner within the legislation are:</p> <ul style="list-style-type: none"> <li>a) a collaborative arrangement in which the nurse practitioner is employed or engaged by one or more medical practitioners or an entity that employs or engages one or more medical practitioners; or</li> <li>b) a collaborative arrangement in which a medical practitioner refers a patient to the eligible nurse practitioner in writing; or</li> <li>c) a collaborative arrangement in which the eligible nurse practitioner and one or more medical practitioners make an agreement in writing, signed by each party; or</li> <li>d) a collaborative arrangement in which the eligible nurse practitioner has acknowledgement from one or more medical practitioners that the practitioner will be collaborating in the care of a patient or patients and tells each patient to whom the arrangement applies that the nurse practitioner will be providing care to the patient within an arrangement with one or more medical practitioners that provides for consultation, referral of the patient, transfer of the patient's care and makes the required records in relation to each patient to whom the arrangement applies.</li> </ul> <p>The types of collaborative arrangements for a Participating Midwife within the legislation are:</p> <ul style="list-style-type: none"> <li>a) a collaborative arrangement in which the eligible midwife is employed or engaged by one or more obstetric medical practitioners or is employed or engaged by an entity that employs or engages one or more obstetric medical practitioners or has an agreement in writing with an entity (other than a hospital) that employs or engages one or more obstetric medical practitioners; or</li> <li>b) a collaborative arrangement in which an obstetric medical practitioner or hospital authorised medical practitioner refers a patient to the eligible midwife, for midwifery treatment, in writing; or</li> </ul>

Key line of enquiry	Finding
	<p>c) a collaborative arrangement in which the eligible midwife and one or more obstetric medical practitioners or hospital-authorised medical practitioners make an agreement in writing, signed by each party; or</p> <p>d) a collaborative arrangement in which the eligible midwife has acknowledgement from one or more obstetric medical practitioners or hospital-authorised medical practitioners that the practitioner will be collaborating in the care of a patient or patients and tells each patient to whom the arrangement applies that the midwife will be providing care to the patient within an arrangement with one or more medical practitioners that provides for consultation, referral of the patient and transfer of the patient's care and makes the required records in relation to each patient to whom the arrangement applies; or</p> <p>e) a collaborative arrangement in which a hospital that employs or engages one or more obstetric medical practitioners formally assesses the eligible midwife's competence, performance and professional suitability and gives the eligible midwife clinical privileges for a defined scope of clinical practice and permits the eligible midwife to provide care to the midwife's own patients at the hospital.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that, in addition to the types of collaborative arrangements as noted in the legislation, there are a number of additional collaborative arrangement models being used across the country and being referred to as a collaborative arrangement. Examples provided included arrangements in hospital settings, private practice and remote collaborative arrangements. It was also found that some Medical Practitioners had established collaborative arrangements with Nurse Practitioners through a verbal agreement, despite this being required.</p>

Key line of enquiry	Finding
<p>Are they purely financial or do they include clinical collaboration requirements?</p>	<p><b>Finding 1</b></p> <p>The National Health (Collaborative Arrangements for Midwives) Determination 2010 and the National Health (Collaborative arrangements for Nurse Practitioners) Determination 2010 state that a collaborative arrangement must provide details of consultations between Nurse Practitioners or Participating Midwives with the Medical Practitioner, referrals to Medical Practitioners and transfer of care to a Medical Practitioner. Written collaborative arrangements place additional obligations on Nurse Practitioners and Participating Midwives to keep specific records (as noted in the respective National Health (Collaborative Arrangements) Instrument 2022 and can often include financial arrangements and additional clinical requirements as stipulated by the Medical Practitioner entering into the arrangement.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that collaborative arrangements are set up to enable Nurse Practitioners and Participating Midwives to access MBS and PBS. It was also found that clinical collaboration is an integral part of Nurse Practitioner and Participating Midwives' practice, regardless of whether they have a collaborative arrangement in place or not.</p>
<p>Are collaborative arrangements appropriate for all clinical settings? Or for some more than others?</p>	<p><b>Finding 1</b></p> <p>In some contexts, collaborative arrangements were found to work well, such as in hospital settings where medical practitioners are readily available and are willing to enter into a collaborative arrangement with Nurse Practitioners. In other contexts, such as rural and remote areas, it was found that collaborative arrangements were harder to enter into due to the lack of available Medical Practitioners which impacts on the Nurse Practitioner's ability to offer MBS rebated services in rural and remote locations.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that collaborative arrangements were not appropriate in all clinical settings, with many stakeholders saying they weren't appropriate in any settings.</p>
<p>Are there similar legislated collaborative care models that exist between Nurse Practitioners/Participating Midwives (or equivalent) and other health professionals internationally? How do they compare with collaborative arrangements in Australia? (Informed by literature only)</p>	<p>A review of the literature indicates that the United States, Canada and Australia are the only countries that legislate collaborative care models between Nurse Practitioners, Participating Midwives and Medical Practitioners. However, in the United States and Canada, Nurse Practitioners and privately practicing Midwives can work with full autonomy in some states/provinces in those countries under the legislation. The United Kingdom and New Zealand have similar Nurse Practitioner and Participating Midwife roles, which require advanced training and clinical practice, however, collaboration with Medical Practitioners is a standard of practice, rather than a legislated model.</p>

Key line of enquiry	Finding
<p>How does a Nurse Practitioners/ Participating Midwives' individual scope of practice relate to their collaborative arrangement? How is the scope documented and assessed by the collaborating Medical Practitioner?</p>	<p><b>Finding 1</b></p> <p>The legislative frameworks do not set out specific requirements in determining and assessing the scope of practice for Nurse Practitioners, Participating Midwives and Medical Practitioners in a collaborative arrangement.</p> <p><b>Finding 2</b></p> <p>Engagement and survey data found that stakeholders held various views as to how a scope of practice related to a collaborative arrangement with many noting that collaborative arrangements don't, or shouldn't, relate to a Nurse Practitioners' or Participating Midwives' scope of practice.</p>
<p>Is there evidence of review/adjustment/transfer of collaborative arrangements over time? (Informed by literature only)</p>	<p>In addition to the different collaborative arrangement models being used as mentioned above, the literature revealed that collaborative arrangement legislation has had minimal evolution since it was introduced in 2010.</p>

## Patients

Key line of enquiry	Finding
<p>Is there evidence of positive or negative patient outcomes, including quality of care and patient wellbeing, as a result of collaborative arrangements?</p>	<p><b>Finding 1</b></p> <p>The literature revealed that the legislation for collaborative arrangement creates barriers to creating private practice Nurse Practitioner services and therefore restricts access to Nurse Practitioners. Barriers include increased wait times and increased patient costs.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that collaborative arrangements were found to have both positive and negative impacts on patient outcomes. Negative impacts included limited access to care through increased cost and delayed care, MBS and PBS restrictions, poor communication between practitioners and misalignment of scope between collaborating practitioners.</p> <p>Positive impacts included the increased level of patient advocacy through engagement with a Nurse Practitioner or Participating Midwife, especially for First Nations people living within metropolitan areas. Also, an increased level of confidence and trust for the patient when Nurse Practitioners, Participating Midwives and Medical Practitioners are working together to deliver continuity of care.</p>



Key line of enquiry	Finding
<p>Do patient demographics (e.g. age, health conditions, residential location, socioeconomic status) have an impact on the efficacy and appropriateness of collaborative arrangements?</p>	<p>The literature revealed that collaborative arrangements can have a negative impact on older patients, patients with a lower socio-economic status, those living rural and remote areas and First Nations people especially those living in remote and very remote areas. This was supported by engagements and survey data. It was found that women had trouble accessing affordable midwifery care in regional areas if the Participating Midwife was unable to secure a collaborative arrangement.</p> <p>Also, where a Nurse Practitioner or Participating Midwife had a collaborative arrangement and was available in a rural or remote setting but no Medical Practitioner was available locally, patients had to travel to a Medical Practitioner to secure a referral to see the locally based Nurse Practitioner or Participating Midwife which disadvantages those in rural and remote locations.</p>
<p>Is there evidence of a flow on impact of collaborative arrangements to patients and the community (positive/negative), specifically in rural and remote settings?</p>	<p><b>Finding 1</b></p> <p>The literature revealed that with the limitations surrounding access to Medical Practitioners in rural and remote settings, collaborative arrangements are considered an unnecessary limitation for Nurse Practitioners and Participating Midwives and the policies and regulations can weaken the position of Nurse Practitioners and Participating Midwives as legitimate health care providers.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that Overarching Organisations, Nurse Practitioner Organisations and Midwives' Organisations all held the view that the impacts, especially the negative impacts, of collaborative arrangements are increased in rural and remote settings.</p>
<p>Is there evidence to suggest potential impacts on patient outcomes if collaborative arrangements are removed?</p>	<p>Most stakeholders held the view that the removal of collaborative arrangements would result in positive impacts on patient outcomes. Removal was thought to improve access to care and choice of provider, it would enable Nurse Practitioners the opportunity to offer their full suite of skills to patients without delays, it would potentially lead to higher uptake of private midwifery models of care. Some stakeholders also held the view that it would not have a negative impact on patient safety as clinical collaboration would continue.</p>

## Administrative/business

Key line of enquiry	Finding
<p>What is the administrative burden of collaborative arrangements? Does it vary between practice models?</p>	<p>Engagements and survey data found that collaborative arrangements pose additional administrative barriers and burden, especially on the Nurse Practitioners and Participating Midwives. There is a legislative requirement for the Nurse Practitioner or Participating Midwife to obtain patient consent, which is necessary with or without collaborative arrangements, but some stakeholders noted it was more extensive and involved the preparation of additional documentation to access Medicare rebates.</p>
<p>Are there clinical/administrative barriers that impact patient care, or access to care, within this model?</p>	<p><b>Finding 1</b></p> <p>The literature revealed that a lack of clarity around liability for Nurse Practitioners and Medical Practitioners impacts on patient care.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that the clinical and administrative barriers that impact on patient care include limited range and roles of health care workers in hospitals, PBS, MBS and Therapeutic Goods Administration prescriptive barriers. These barriers impact patients where collaborative arrangements have not been established, resulting in increased costs and restricted access to care.</p>
<p>What are the impacts of Nurse Practitioner/ Participating Midwife collaborative arrangements on the private practice of Nurse Practitioners and Participating Midwives?</p>	<p><b>Finding 1</b></p> <p>The literature revealed that collaborative arrangement practices inhibit Nurse Practitioners or Participating Midwives from being able to develop or establish their own private practice.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found a number of impacts which included challenges related to securing a collaborative arrangement, restrictions on their ability to practice their full scope, impact on income potential and autonomy of practice.</p>

Key line of enquiry	Finding
<p>What are the impacts of Nurse Practitioner/ Participating Midwife collaborative arrangements for participating Medical Practitioners or medical practices?</p>	<p><b>Finding 1</b></p> <p>Literature identified that collaborative arrangements can be viewed as both an alleviation of Medical Practitioner workloads or an additional workload.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that there were a number of impacts on collaborative arrangements for participating Medical Practitioners or medical practices. Positive impacts included the ability to distribute the workload and improved patient access to care. Negative impacts included Medical Practitioners perceived responsibility for oversight of the Nurse Practitioner or Participating Midwife, increased liability and Medical Practitioners being involved in the provision of care but not being paid. Some organisations felt there was no impact at all, particularly if the collaborative arrangement was a remote agreement.</p>
<p>Do collaborative arrangements have cost implications, including for the cost of professional indemnity insurance?</p>	<p><b>Finding 1</b></p> <p>Peak medical organisations note that a Medical Practitioner's indemnity insurance will cover liabilities associated with collaborative arrangements, as long as the Medical Practitioner is in the correct risk category.</p> <p><b>Finding 2</b></p> <p>Engagements and survey data found that most stakeholders were unable to state whether there were cost implications or not. All parties need to have professional indemnity insurance and while some attributed this to a cost implication with collaborative arrangements, others stated that the cost was the same regardless.</p>

## System

Key line of enquiry	Finding
<p>Are there any documented cases/evidence in which not having a collaborative arrangement in place has had an impact on Nurse Practitioner, Participating Midwife insurance schemes, Medical Practitioners, private or public funders? (Informed only by engagements and survey data)</p>	<p>Stakeholders did not identify any documented cases or evidence relating to a lack of collaborative arrangements impacting on insurance. Stakeholders generally felt that the removal of collaborative arrangements was unlikely to affect private or public funders. They also held the view that funders would experience less barriers to set up models of care if collaborative arrangements were removed.</p>

Key line of enquiry	Finding
<p>Is there evidence on system impacts related to the removal of collaborative arrangements? For example, might fragmentation of care occur in the absence of legislated collaboration? (Informed only by engagements and survey data)</p>	<p>Most stakeholders (74% of survey participants and 72% of interview participants) felt that the removal of collaborative arrangements would be beneficial and not lead to fragmentation of care. However, it would be essential to ensure collaboration continued and that legislation remained to keep current Medicare and PBS access in place.</p> <p>Of the remaining 28%, some Medical Practitioners and Overarching Organisations felt that removal of collaborative arrangements could result in fragmented care. However, the main reasoning was the assumption that removal of collaborative arrangements would lead to a reduction in collaborative care overall.</p>

# References



1. Australian College of Nurse Practitioners (2021) *Annual Report 2020-2021*.
2. Australian Government (2012) *Collaborative Arrangements for Participating Midwives and Nurse Practitioners Fact Sheet*.
3. Australian Government (2021) National Health Workforce Dataset. Accessed via: <https://hwd.health.gov.au/nrmw-dashboards/index.html>.
4. Australian Government (2010) *Explanation Statement National Health (Collaborative arrangements for nurse practitioners) Determination 2010*.
5. Australian Government (2013) *National Health (Collaborative arrangements for midwives) Amendment Determination 2013*.
6. Australian Government (2020) *Section 11 Equity Groups*. Accessed via: <https://www.education.gov.au/higher-education-statistics/resources/2020-section-11-equity-groups>.
7. Australian Government Department of Health (2021) *Nurse Practitioner 10 Year Plan Consultation Paper*. Australian Government, Canberra.
8. Australian Government Department of Health and Ageing (2005) *Submission to the Productivity Commission: Health Workforce Study*. Australian Government, Canberra.
9. Australian College of Nurse Practitioners (2022). *Collaborative Arrangements*. <https://www.acnp.org.au/collaborative-arrangements>.
10. Australian Nursing and Midwifery Federation (2021). *Pre-Budget Submission 2021-2022*.
11. Australian Medical Association (2010) *Collaborative arrangements what you need to know*. Australian Medical Association, Australian Capital Territory.
12. Canadian Institute for Health Information (2020a) *Nurse practitioner scopes of practice in Canada*. Accessed via: <https://www.cihi.ca/en/nurse-practitioner-scopes-of-practice-in-canada-2020>.
13. Canadian Institute for Health Information (2020b) *Nurse practitioner scopes of practice vary across Canada's provinces and territories*. Accessed via: <https://www.cihi.ca/en/nurse-practitioner-scopes-of-practice-vary-across-canadas-provinces-and-territories>.
14. Canadian Nurses Association (2022) *Nurse Practitioners*. Accessed via: <https://www.cna-aiic.ca/en/nursing/advanced-nursing-practice/nurse-practitioners>.
15. Cashin, A., Stasa, H., Dunn, S. V., Pont, L. and Buckley, T. (2014). Nurse practitioner prescribing practice in Australia: Confidence in aspects of medication management. *International Journal of Nursing Practice*, 20(1).
16. Chiarella, M., Currie, J. and Wand, T. (2019). Liability and collaborative arrangements for nurse practitioner practice in Australia. *Australian Health Review*, 44(2).
17. Clarke, E. (2022). Nurse Practitioner Practice Authority: A State-by-State Guide. *Nurse Journal*. Accessed via: <https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/>.
18. Columbia University Irving Medical Centre (2014). *Nurse Practitioners Modernization Act Becomes Law*. Accessed via: <https://www.cuimc.columbia.edu/news/nurse-practitioners-modernization-act-becomes-law>.
19. Currie, J., Chiarella, M. and Buckley, T. (2013). An investigation of the international literature on nurse practitioner private practice models. *International Nursing Review*, 60(4).
20. Currie, J., Chiarella, M. and Buckley, T. (2017). Privately practising nurse practitioner activities in Australia and their potential to lead advanced practice into the future. *Journal for nurse practitioners*, Vol.13 (7), 331-e331.
21. Currie, J., Chiarella, M. and Buckley, T. (2016) Collaborative arrangements and privately practising nurse practitioners in Australia: results from a national survey. *Australian Health Review*, 41(5), 533-540. CSIRO Publishing.
22. Department of Health and Aged Care (2023). Health Workforce Data. Australian Government. Accessed via: <https://public.tableau.com/app/profile/healthworkforcedata/viz/Factsheets20230224>.

23. Dwyer, T., Craswell, A. and Browne, M. (2021). Predictive factors of the general public's willingness to be seen and seek treatment from a nurse practitioner in Australia: a cross-sectional national survey. *Human Resources for Health*, 19(1).
24. Evans, C., Pearce, R., Greaves, S. and Blake, H. (2020). Advanced Clinical Practitioners in Primary Care in the UK: A Qualitative Study of Workforce Transformation. *International Journal of Environmental Research and Public Health*, 17(12).
25. Foster, J. P. (2010). A history of the early development of the nurse practitioner role in New South Wales, Australia. *ResearchGate; University of Technology*, Sydney.
26. Fong, J., Buckley, T., Cashin, A. and Pont, L. Nurse practitioner prescribing in Australia: A comprehensive literature review. *Australian Critical Care*, 30(5): 252-259.
27. Homer, C., Davies-Tuck, M., Dahlen, H., Scarf, V (2021). The impact of planning for COVID-19 on private practising midwives in Australia. *Women and Birth*, 34(1): 32-37.
28. International Confederation of Midwives (2022) *ICM Definitions*. Accessed via: <https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html>.
29. Jennings, N., Clifford, S., Fox, A. R., O'Connell, J. and Gardner, G. (2015). The impact of nurse practitioner services on cost, quality of care, satisfaction and waiting times in the emergency department: A systematic review. *International Journal of Nursing Studies*, 52(1).
30. King, R., Tod, A. and Sanders, T. (2017). Development and regulation of advanced nurse practitioners in the UK and internationally. *Nursing Standard*, 32(14).
31. Kruth, T. (2022). *Advanced Practice Nursing in the United Kingdom (England, Wales, Scotland, and Northern Ireland)*. International Advanced Practice Nursing.
32. Kuo, Y., Loresto, F., Rounds, L. and Goodwin, J. (2013). States with the least restrictive regulations experienced the largest increase in patients seen by nurse practitioners. *Health Affairs*, 32(7):1236-43.
33. MacLellan, L., Higgins, I. and Levett-Jones, T. (2015). A game of snakes and ladders: Negotiating the "ups and downs" of endorsement as a nurse practitioner in Australia. *Contemporary Nurse*, 50(2-3).
34. Mark, B. A. and Patel, E. (2019). Nurse Practitioner Scope of Practice: What do we know and where do we go? *Western Journal of Nursing Research*, 41(4), 483–487.
35. Martin, M and Reneau, K. (2020). How Collaborative Practice Agreements Impede the Administration of Vital Women's Health Services. *J Midwifery Womens Health*, 65(4), 487-495.
36. Martsof, G. R., Kandrack, R., Ferrara, S. A., & Poghosyan, L. (2023). The Impact of the New York Nurse Practitioner Modernization Act on the Employment of Nurse Practitioners in Primary Care. *The Journal of Health Care Organization, Provision, and Financing*, 60.
37. Medway, P., Sweet, L. and Muller, A. (2021). *Barriers and enablers for midwives to use the Nursing and Midwifery Board of Australia's Endorsement for scheduled medicines for midwives*. *Women and birth: journal of the Australian College of Midwives*, 34(1).
38. Middleton, S., Gardner, A., Della, P. R., Lam, L., Allnutt, N. and Gardner, G. (2016). How has the profile of Australian nurse practitioners changed over time? *Collegian*, 23(1).
39. Midwife Schooling. *State Regulations for CNMs*. Accessed via: <https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states/>.
40. Midwifery Council (2022). *The Midwifery Scope of Practice*. Accessed via: <https://midwiferycouncil.health.nz/Public/Public/01.-Midwifery-in-Aotearoa-New-Zealand/The-Midwifery-Scope-of-Practice.aspx>.
41. Ministry of Health (2022). *Nurse Practitioners in New Zealand*. New Zealand Government, Wellington. Accessed via: <https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand>.
42. National Health and Medical Research Council (2010) *National Guidance on Collaborative Maternity Care*. Canberra: National Health and Medical Research Council.
43. Neff, D., Yoon, S., Steiner, R., Bejleri, I., Bumbach, M., Everhart, D. and Harman, J. (2018). The impact of nurse practitioner regulations on population access to care. *Nurse Outlook*, 66(4):379-385.

44. New York State Education Department Office of the Professionals (2015). *Practice Requirements for Nurse Practitioners*. Accessed via: <http://www.op.nysed.gov/prof/nurse/np-prfnp.pdf>.
45. Nursing and Midwifery Board of Australia (2016) *Registered Nurse Standards for Practice*. Accessed via: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx>.
46. Nursing and Midwifery Board of Australia (2016) *Midwife Standards for Practice*. Accessed via: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx>.
47. Nursing and Midwifery Board of Australia (2019) *Guidelines: For nurses applying for endorsement as a nurse practitioner*. Accessed via: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Guidelines-on-endorsement-as-a-nurse-practitioner.aspx>.
48. Nursing and Midwifery Board of Australia (2021) *Nurse Practitioner Standards for Practice*. Accessed via: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx>.
49. Pritchard, R., Foster, J. and Chiarella, M. (2010) Guest editorial: Historic legislation for nurse practitioners and midwives: recognised potential in health reform. *Neonatal, Paediatric and Child Health Nursing* – July 2010, 13 (2).
50. Poghosyan, L., Ghaffari, A., Liu, J., Martsof, G. (2021) State policy change and organizational response: Expansion of nurse practitioner scope of practice regulations in New York State. *Nursing Outlook*, 69 (1), 74-83.
51. Queens University (2020). *Glossary of human rights terms*. Retrieved from Ontario Human Rights Commission (2017). Accessed from: [https://www.queensu.ca/hreo/sites/hreowww/files/uploaded\\_files/20201210KeyEDlIterms.pdf](https://www.queensu.ca/hreo/sites/hreowww/files/uploaded_files/20201210KeyEDlIterms.pdf).
52. Rodgers, M. and Gloster, A. (2020). Advanced Practice Nursing in the United Kingdom. *Advanced Practice Nursing Leadership: A Global Perspective*.
53. Resnick, B. and Nettina, S. (2010). Should a Written Collaborative Practice Agreement with a Physician Be Required for Nurse Practitioner Practice? *The Journal for Nurse Practitioners*, 6(3), 199-200.
54. Ritter, A. Z., Bowles, K. H., O'Sullivan, A. L., Gilman, D. J. and Fairman, J. A. (2020). Nurse practitioner state-required collaborative practice agreements: A cross-sectional case study in Florida. *Nursing Economics*, 38(4), 185–193.
55. Sarasua, I. and Kozakiewicz, C. (2021). *New legislation brings big changes for Quebec nurse practitioners and patients*. Accessed via <https://www.mcgill.ca/nursing/article/new-legislation-brings-big-changes-quebec-nurse-practitioners-and-patients>.
56. Schadewaldt, V., McInnes, E., Hiller, J. E. and Gardner, A. (2013). Views and experiences of nurse practitioners and medical practitioners with collaborative practice in primary health care – an integrative review. *BMC Family Practice*, 14(1).
57. Schadewaldt, V., McInnes, E., Hiller, J. E. and Gardner, A. (2016). Experiences of nurse practitioners and medical practitioners working in collaborative practice models in primary health care in Australia – a multiple case study using mixed methods. *BMC Family Practice*, 17(1).



