

Middle level clinicians – a role in rural Australia?

Ian Cameron, NSW Rural Doctors Network

The last few years have increasingly seen a focus on primary health care teams as the structural foundation of rural health care. While the term 'primary health care' remains largely undefined in an industrial nation, and almost entirely undescribed in rural areas in industrial nations, it has come to be shorthand for health professionals who have first individual patient contact within an ethos that encourages population and preventative health.¹

While there has been a focus on the 'team', there has been little formal movement about the roles of the team members. Certainly there has been some broadening of professional roles, and some narrowing into areas of interest or specialty area. However the team itself has continued to be composed of members defined by their professional position, rather than the team being constructed by the skills mix required.

In rural areas the 'primary health care team' has been seen as an answer to endemic health workforce shortage. While there appears to be little evidence that this would be so, there is certainly evidence that Government initiatives and the energy of rural health organisations and individuals has been improving at least rural health professional numbers. Maybe it is time to look again at how the required skills mix can best be provided in rural areas, how those skills become part of a team, and to do this from a position of rural success rather than a second best answer to rural workforce shortage.

One of those successes has been the RDN / RARMS experience in remote north west NSW. From 2001 a change in General Practice structure has resulted in

- more doctors
- more personal services
- more population health services
- a decrease in hospital outpatient services
- a decrease in population morbidity as measured by hospital in-patient use
- an increase in community based non-doctor health workers.

WHERE TO FROM HERE?

A concrete integrationist approach would focus on better or total integration between health services provided through the GP surgery, the Aboriginal Medical Service and the NSW Health Community Health Centre. While this would be admirable, and would build on the ad hoc integration that is a feature of rural life, on its own it does not address a basic question of what services are needed, and who in rural health is best placed to provide them. The Walgett experience is only one of many which provide a platform to extend beyond the integration of existing professional boundaries to looking at putting together a team that includes the right skill mix. One way to start is to look at Australian and overseas experiences of the non-doctor clinician.

MIDDLE LEVEL CLINICIANS – A SHORT REVIEW

There are numerous descriptions of non-doctor clinicians, but in practice they tend to fall into two main groups, Nurse Practitioners and Physicians Assistants. These have been defined in the USA as:

A Nurse Practitioner / Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and / or country in which s/he is credentialed to practice.

Physician assistants are health professionals licensed or, in the case of those employed by the federal government, credentialed, to practice medicine with physician supervision.Within the physician / PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. The clinical role of physician assistants includes primary and specialist care in medical and surgical practice settings in rural and urban areas.²

Nurse practitioner

- Builds on basic nursing training
- May be hospital or community based
- May be generalist or specialist
- May be independent practitioners
- Limited prescribing rights
- ? Nursing shortage³
- More, ? better services
- Do not reduce doctor time in community setting⁴

Practice nurses

- Nursing training
- Generalist
- Community based
- Role in population and preventative
- Can extend services in community setting

Physicians assistants aka clinical associates⁵

- Since 1600s
- Increase in USA from 1960s
- In USA over 40 000

- 70% Community based
- Now also in UK and Canada⁶
- Medical training⁷
- Regulated by State Medical Board
- Generalists
- Contracted to doctor
- Delegation from doctor
- Paid by doctor
- Doctor substitute
- Limited prescribing rights

Medical assistants

- Administration with some clinical skills
- Brisbane North Division of General Practice⁸

Specialist technicians

- Specialists
- Usually hospital based
- Narrow education
- Non-graduate
- Under-utilised in Australia

WHAT CAN BE DONE?

There needs to be a description, if not a definition of what 'primary health care' is in rural areas in a developed country. This needs to take into account that community based health professionals in rural areas also form the hospital workforce, that health professionals in rural areas also provide secondary and in some cases tertiary care, that "first contact" includes professionals other than doctors and nurses (allied health, Aboriginal health workers, ambulance officers), and that funding models should penalise rather than reward primary care activity which takes place at a secondary or tertiary level⁹ (eg when a specialist surgeon performs procedures that could be done at a primary care level a higher fee is currently paid to the surgeon than if it was done by a GP).

A skills mix approach needs to look at health workers having roles outside the professional delineations that currently exist. In the hospital setting this could include GPs doing middle level anaesthetics, leaving the few specialist anaesthetists free to do the more complicated cases, nurse practitioners doing other anaesthetics. Specialist technicians can replace registered

nurses as OT assistants, leaving the RNs free to take on more complex roles. In the community setting there can be a much greater role for nurse practitioners, practice nurses and clinical associates in all aspects of personal, population and preventative health. In many places ambulance officers form an unrecognised first line of community health monitoring, and at the same time can have their advanced training under-utilised.

At the heart of any skills mix system is **delegation**, both skill and financial. In a hospital setting where people are employed under standard awards or agreements the skill delegation is already standard, and largely governed by competency and training. There remains an opportunity for room for movement in who gains what competencies, which health professionals can take on different roles.

In the community setting, and where private practice and fee-for-service from patient are more common, the key is in delegation of activity which continues to attract a fee. For instance in the doctor – clinical associate situation, the clinical associate is employed by, and contracted to, the doctor. The doctor collects fees and pays the clinical associate, although in most cases the doctor will not see the patient. The doctor has delegated a clinical activity to the associate. In Australia this would require regulatory and legislative change.

WHO CAN DO IT?

Australia has a plethora of rurally based and rurally focused organisations which could build non-doctor clinician systems. Much of the ground work for practice nurses and nurse practitioners has been laid or is operating. The Nursing Colleges, universities and CRANA all have a continuing role. For physician assistant / clinical associate there are educational curricula in existence that could be further developed by University departments of Rural Health and Medical Schools. As in the USA it could be expected that State Medical Boards would take responsibility for certification and regulation. Rural Workforce Agencies and Divisions could both have a role in continuing education and in workforce development. Governments would need to be involved in changing regulation and legislation to allow delegation, both financial and skill. Again, there exists a wonderful opportunity for all our organisations to work together in bringing a new pathway in rural health workforce.

PRESENTER

Ian Cameron grew up and was a GP in Bourke. Lately he has been CEO of the NSW Rural Doctors Network, seeking to improve recruitment and retention of doctors and other health professionals in rural and remote NSW. He has been involved in looking at a required skill mix rather than professional delineation approach to health workforce planning. Apart from numerous rural health committees, Ian is also a member of the NSW Child Death Review Team and West Pacific representative on the Executive Committee of The Network – Towards Unity For Health, a WHO affiliated organisation seeking to promote partnership approaches in health education and service delivery.

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