Australian College of Nurse Practitioners response to:

COVID-19 RESPONSE INQUIRY PANEL

- COVID-19 Response Inquiry

Australian College of Nurse Practitioners

A: PO Box 33175 Melbourne Vic 3004 | Office: St Kilda Rd Towers, Suite 502, 1 Queens Road Melbourne

E: admin@acnp.org.au P: 1300 433 660 W: www.acnp.org.au

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Commonwealth Government COVID-19 Response Inquiry Panel
By online upload before 15 December 2023

Dear Panel Members

Thank you for the opportunity to provide a response to the COVID-19 Response Inquiry.

The Australian College of Nurse Practitioners (ACNP) is the national peak organisation for Nurse Practitioners, advancing nursing practice and consumer access to health care. A key focus for the role and scope of practice development for Nurse Practitioners is on unmet needs within the community and increasing access to health care.

In this submission, the ACNP will draw attention to the exclusion of nurse practitioners from the vaccine rollout, lack of engagement with the nurse practitioner workforce, obstacles in obtaining essential Personal Protective Equipment (PPE) for nurse practitioners, and a disparity in the fair distribution of COVID-19 vaccinations. This disparity is notably evident in vulnerable regions such as Aboriginal communities and rural/remote areas.

Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, quarantine facilities, and public health messaging).

Lack of Nurse Practitioner Consultation on Strategic Programs

While there were delays in establishing partnerships with private and government entities, including mining companies, police, prisons, community pharmacists, community-based organisations, and shires, hindering effective collaboration in vaccine distribution; the complete exclusion of Nurse Practitioner consultation in state and federal strategic programs is a notable oversight. Engaging Nurse Practitioners in the development and implementation of strategic initiatives would have contributed to a more comprehensive and well-informed approach to healthcare delivery. Nurse Practitioners, and the Australian College of Nurse Practitioners were excluded from all planning within the Australian Government

Department of Health (DOH) in relation to the COVID-19 pandemic and vaccinations, and variable engagement was seen in different States and Territories. Notably, the DOH was focussed almost exclusively on a medical (and later, Pharmacy) response, and did not engage with other health professions.

It was only through our advocacy that ACNP were included in the Primary Care COVID-19 Response teleconference meetings after they were already established. Through regular attendance at that meeting, we were finally able to ensure NPs had access to PPE through the national stockpile after all other attempts to ensure supply had failed or been ignored. We were able to arrange meetings with relevant people within DOH about NPs being excluded from the vaccine rollout in primary care through our work within this group.

Barriers for Nurse Practitioners in Primary Healthcare

Nurse practitioners were treated inequitably during the Australian response to COVID19. Instead of harnessing the most senior nurses in the healthcare landscape, the Australian government chose to install barriers between nurse practitioners and their patients.

Privately practicing nurse practitioners working in primary healthcare settings faced many challenges during the COVID-19 pandemic. Some of the key challenges included:

Access to PPE

Nurse practitioners encountered difficulties in obtaining sufficient and appropriate PPE, which is crucial for their safety and the safety of their patients. Shortages and distribution issues created significant challenges in maintaining infection control measures. For instance, barriers faced by nurse practitioners in accessing masks during the initial response period must be recognised. PHN's were instructed by DOH to release PPE from the National Stockpile only to GP clinics and were refusing to release PPE to NP led clinics and services. Initial feedback on this from DOH was that NPs were unlikely to see anyone with COVID 19, and later, that the assistance of NPs during the pandemic was not needed. A few PHNs did release some PPE to NPs in parts of Australia, however it wasn't until they were ordered to, following advocacy from the chair of the Primary Care COVID-19 Response teleconference, that we saw consistent supply. The delay was in excess of six weeks, as COVID 19 numbers rapidly rose and spread across the country, prior to vaccine availability.

Adaptation to Telehealth Services

The transition to telehealth services presented a learning curve for many nurse practitioners in primary

care. Adapting to virtual consultations and managing patient care remotely required adjustments in communication methods and technology use. Some nurse practitioners faced challenges related to technology barriers, including limited access to digital resources and potential disparities in patients' ability to engage in virtual healthcare.

While the adoption of telehealth services became crucial during the pandemic, the transition posed financial challenges. Reimbursement rates for nurse practitioner telehealth services were lower than for consultations with a general practitioner, impacting the financial viability of these remote consultations.

Nurse Practitioners, however, embraced these changes and the technology associated, covering the associated costs themselves without incentives afforded to other providers to support change and implementation.

Reduced Patient Visits and Revenue

Nurse practitioners operating in independent practices faced greater financial challenges, as they lack the financial backing and resources of larger healthcare organisations. The pandemic's economic impact on the broader community also influenced the ability of patients to pay for healthcare services. Navigating these financial challenges required adaptability, strategic planning, and, in some cases, external support or relief measures to ensure the continued provision of quality healthcare services.

Many primary healthcare practitioners experienced a decline in patient visits, as people postponed non-urgent medical appointments due to fears of contracting COVID-19. This decrease in patient volume directly impacted practitioners' revenue, as fees for services constitute a significant portion of their income.

This affected nurse practitioners in primary care as it did other primary care providers, however there was no support available to nurse practitioner clinic owners, and patient presentations did not increase when vaccines became available as it did in GP clinics, as nurse practitioners were entirely excluded from the vaccine rollout.

Vaccine programs

Vaccine Program Requirements

Privately practicing nurse practitioners were not allocated a Medicare Benefits Schedule (MBS) item number for the administration of the COVID-19 vaccine, unlike General Practitioners. Additionally, a prerequisite was established, mandating the presence of a General Practitioner on-site at the clinic for the

administration of COVID-19 immunisations. Consequently, this restriction impeded patient access to vaccination services solely provided by Nurse Practitioners. It curtailed the autonomy of Nurse Practitioners, hindering their ability to function as independent vaccinators and limiting their capacity to offer a broader range of services. This constraint included the inability to conduct home visits or provide services in the wider community, such as to patient residences or aged care facilities.

Industry wide concern arose when it became apparent that nurse practitioners could only administer the vaccine under the supervision of a general practitioner or a "suitably qualified health professional." From January 2021 the matter was consistently brought to attention by the ACNP and other peak bodies including Australian Nursing & Midwifery Federation (ANMF), CRANAplus, Australian Primary Health Care Nurses Association (APNA), Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Australian College of Perioperative Nurses (ACORN) by initiating discussions with the federal government regarding this omission.

Leanne Boase, our President at the time, attended a videoconference meeting with [redacted] on 5/8/2021, and other DOH representatives to discuss the exclusion of the primary care Nurse Practitioner workforce, and was told that the assistance of Nurse Practitioners was not required, and no changes would be made to the vaccine rollout. It was made clear that no further discussions would be entered into.

In September 2021, a 'Request for Tender' (RFT) process was initiated, enabling privately practicing nurse practitioners to participate. ACNP believes this RFT was the result of strong advocacy by the Office of the Commonwealth Chief Nurse, trying to ensure nursing was fully utilised in the pandemic response.

The RFT process was intricate and protracted, demanding a considerable effort for application, a substantial business structure for eligibility, and meticulous attention to various non-clinical requirements. The process also appeared to introduce a competitive dynamic in determining eligibility for participation in vaccination efforts. The exclusion of a qualified profession or business could be regarded as contrary to principles of fair competition. In the Australian context, it's notable that, while the Competition and Consumer Act (2010) is in place, its applicability to government actions seems to be restricted.

Access to the COVID-19 Vaccination Program remains a problem for patients of Nurse Practitioners and will be until the vaccine is included onto the National Immunisation Program Schedule.

Vaccine Distribution Challenges

Nurse practitioners encountered difficulties in certain areas regarding the distribution and application of COVID-19 vaccines. These challenges encompassed logistical hurdles, disparities in vaccine accessibility, and the need to adapt quickly to changing vaccination priorities and guidelines. Notably, Nurse Practitioner clinics were unable to register for vaccine orders, despite many NP practices being registered to store and administer government funded vaccines on the Australian Immunisation Register (AIR).

Challenges in vaccine handling, maintenance of the cold chain, and adherence to expiry time requirements

impeded timely vaccine distribution in the first 3 months of the vaccine program. Initial uncertainty over vaccine stability resulted in transport barriers, impacting the efficient delivery of vaccines to remote regions. Resolving these logistical challenges was crucial to ensuring a more efficient and widespread vaccine distribution. Existing frameworks and resources, including existing vaccine providers meeting AIR requirements should have been fully utilised. Even now, the COVID-19 vaccination is excluded from the National Immunisation Program Schedule, continuing to add unnecessary costs and complexities to the delivery and administration.

Pfizer deliveries to WA regional areas in the first 3 months of the program were hand delivered by public health employees who acted as couriers. This was prohibitively expensive and time-consuming. For every delivery of 50-100 vaccines, this process included airline arrangements for exemption from screening, flight and transport bookings and police escorts. Handover of this responsibility to a courier company in week 14 meant that efforts were able to be directed to other areas of the vaccine program.

Workforce

Chronic shortages in rural and remote areas compounded by workforce shortages emerged as a major impediment to vaccine access. Nurse Practitioners in primary care were notably excluded from vaccine administration plans, leading to delays in critical areas. Recognising the expertise of nurse practitioners is crucial for effective and inclusive vaccination strategies.

Vaccination Delivery Challenges in Rural Areas

The disparities in vaccine accessibility heightened the risks in vulnerable communities, particularly among Aboriginal populations. There were significant delays in establishing a 'business as usual' model for vaccine delivery to rural areas as well as missed opportunities to leverage existing systems and models for efficient distribution. For instance, consideration of processes to make COVID-19 vaccines routinely available in rural emergency health services for vulnerable populations did not commence until Feb-June 2022. The necessity of working with an onsite General Practitioner posed challenges in rural and remote areas, occasionally leading to the bypassing of this requirement to facilitate vaccine administration, placing fully qualified and experienced health practitioners at risk.

Communication Challenges

Clear and timely information dissemination to communities on accessing vaccine clinics was challenging resulting in low awareness levels among community and aged care workers. Booking facilities were poor, with phone lines congestion and complex booking systems. Information provided by Primary Health Care

Networks was inconsistent across the country with some being very involved and inclusive of Nurse Practitioners while others were not.

The ACNP urges the Inquiry panel to consider these specific issues in formulating recommendations and strategies for a more robust and efficient health response. Collaborative efforts and a whole-of-government approach are paramount to mitigating the impacts of future pandemics on our communities.

It is the belief of the ACNP that a more expeditious and efficient vaccine rollout could have been achieved if the federal government had leveraged the expertise of nurse practitioners, and our existing vaccine programs and infrastructure. Not only would nurse practitioners have contributed to a faster rollout, but their involvement could have also enhanced the impact through educational initiatives and comprehensive follow-up care.

Thank you for your attention to these crucial matters. We remain committed to supporting comprehensive and inclusive health responses.

Thank you again for the opportunity to participate in this important review.

Yours sincerely

Leanne Boase
Chief Executive Officer
Australian College of Nurse Practitioners
PO BOX 33175 Melbourne VIC 3004
St Kilda Rd Towers, Suite 502, 1 Queens Road Melbourne
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