Collegian (2016) xxx, xxx–xxx

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/coll

The internationally present perpetual policy themes inhibiting development of the nurse practitioner role in the primary care context: An Australian–USA comparison

Andrew Cashin, RN, MHN, NP, Dip App Sci, BHSC, GCert PTT, GCert HPOL, MN, PhD, FACNP, FACMHN, FCN[a,*], Theane Theophilos, RN, BNurs, BAppSci, GDip, MPH&TM[a], Roger Green, DNP, FNP-BC, RN, FAANP[b]

[a] *School of Health & Human Sciences, Lismore Campus, Southern Cross University, PO Box 157, Lismore, NSW 2480, Australia*
[b] *California State University Dominguez Hills, 1000 East Victoria Street, Carson, CA 90747, USA*

Received 4 August 2015; received in revised form 11 April 2016; accepted 8 May 2016

KEYWORDS
Nurse practitioner;
Primary health;
Mental health;
Nursing workforce

Summary This paper plots international evidence of nurse practitioner efficacy, cost and quality against identification and discussion of barriers of nurse practitioner practice reported in the Australian and United States of America primary care contexts. It is identified that the evidence for the full utilisation of nurse practitioners as an integrated part of health service management internationally is strong, yet significant barriers remain to this happening in both countries. The barriers discussed remain consistent across time despite the evidence that has emerged. This phenomenon of consistent barriers, despite evidence of nurse practitioner efficacy, reasonable cost, and high quality is discussed as a clear example of where evidence alone is not enough to change policy.

1. Introduction

Internationally as societal demographics have changed with an ageing population and an increased prevalence in chronic disease many service gaps have emerged in health care delivery. Despite a multitude of well-constructed studies demonstrating the safety of nurse practitioner (NP) care

* Corresponding author. Tel.: +61 2 6620 3156.
E-mail addresses: Andrew.Cashin@scu.edu.au (A. Cashin), theane.theophilos@scu.edu.au (T. Theophilos), Drrogergreen@aol.com (R. Green).

http://dx.doi.org/10.1016/j.colegn.2016.05.001
1322-7696/

Please cite this article in press as: Cashin, A., et al. The internationally present perpetual policy themes inhibiting development of the nurse practitioner role in the primary care context: An Australian–USA comparison. *Collegian* (2016), http://dx.doi.org/10.1016/j.colegn.2016.05.001

and equivalence with other primary care providers internationally in terms of outcomes, there continues to be policy obstacles preventing the required workforce development that includes models of care optimising NP contributions. Although the nature of the obstacles has evolved over time, such as from access to third party reimbursement to level of reimbursement in both the United States of America (USA) and Australia, the themes have remained remarkably consistent across time despite the emergent evidence. It is obvious from a review of the available evidence that empirical evidence alone is not enough to create the requisite enabling policies for full expression of nurse practitioner scope of practice internationally. The movement from evidence to policy is not a linear process (Head, 2010). Policy formation is influenced by political imperatives and practice based knowledge as well as empirical evidence (Head, 2008). A perpetual cycle has been present where government has viewed medicine as the practice based experts for healthcare and hence the major point of contact for consultative processes and the interpretation of evidence. This has resulted in policy outcomes that have limited the full expression of the possibilities of NP practice in the primary care context.

2. Background

2.1. Australia and USA context

There is strong evidence that NPs are well placed to contribute to filling the gaps in service provision in primary care, so why have not policy levers emerged to encourage this? This paper juxtaposes the Australian and North American context examining NP evolution and practice with particular emphasis on perpetual policy inhibitors to full expression of the NP scope of practice. The international evidence related to efficacy, cost and quality is comprehensively gathered and reviewed in this paper and organised in a manner to clearly show that the barriers that exist to the full expression of the scope of NP embedded in Australian and USA policy are not related to the international evidence of efficacy, cost, or quality and acceptability. Further it is revealed that the strong evidence of efficacy, quality and acceptability has not proportionately impacted upon the policy process. The USA was chosen to contrast the Australian setting due to the long history of NP practice, similarities with the Australian healthcare system, namely a mixture of third party reimbursement and user pays and also the availability of quality research. Although developing in completely independent systems and with different local drivers, on the macro level enough similarity exists to make the comparison meaningful.

Mental health care is one example of many in which the primary health care system is challenged. There is an acute need for mental health nurse practitioners and mental health interventions delivered by primary care and family nurse practitioners in primary care settings in both the USA and Australia (Theophilos, Green, & Cashin, 2015). Mental health is chosen as a focus of the reimbursement example in this paper as mental health care is an area in which a gap has been identified in primary care service delivery (Theophilos et al., 2015). Nurse practitioners are well placed to develop models of care that incorporate identification of and treatment for people with mental illness in a primary care context (Cashin, Green, & Buckley, 2015).

2.2. Burden of mental disorders

There is an acknowledged increasing burden of disease within the primary care context related to the ageing 'baby boomers' or 'greying of America', and consequently increasing index of chronic disease. This increased demand is compounded by rising patient expectations and reforms shifting care from the hospital to community settings e.g. deinstitutionalisation of psychiatric care (Dyer, Hammill, Regan-Kubinski, Yurick, & Kobert, 1997; Laurant, Hermens, Braspenning, Sibbald, & Grol, 2004). Particularly high-risk groups acknowledged in the literature are low-income households, the unemployed/under-employed, ethnic minorities, children, adolescents and the elderly (Dyer et al., 1997).

Health literature has reported between 22% and 25% yearly prevalence of mental illness in the USA (Jordow, 2014; Puskar & Bernardo, 2002) with a lifetime prevalence of 50% (Jordow, 2014). Thus, mental illness accounts for 15% of the total burden of disease. In Australia, a yearly prevalence of 11—20% has been reported (Wand & White, 2007) with a lifetime prevalence of 45% (ABS, 2007). Depression can be a life threatening illness, with suicidal ideation reported commonly (McIlrath, Keeney, McKenna, & McLaughlin, 2010). As an example of service gaps in primary care it is estimated that 50% of depression and anxiety is undiagnosed and consequently untreated (McIlrath et al., 2010; O'Brien, Hughes, & Kidd, 2006).

2.3. Physician shortage in primary care compounding issues of high burden of disease

There is currently an acknowledged physician shortage in the USA (Dill, Pankow, Erikson, & Shipman, 2013). As Physicians have traditionally made up a large component of the primary care workforce a shortage means that the inflated rates of untreated mental illness, and other disorders will grow even further. It has been asserted that by 2025 most primary care physicians may have gone from the healthcare care landscape and that this will pose a real challenge to the Obama health reforms (Levin & Bateman, 2012). Australian predictions are that by 2025 there will be a medical workforce deficit of 2701 physicians, and a deficit of 109,490 nurses (Health-Workforce-Australia, 2012). These shortages are especially well documented in the specialised area of mental health/psychiatry for both the USA (Ashby, 2006) and Australian contexts (Fisher, 2005).

So while burden of disorders is high and placing strain on primary care services, supply of physicians is not keeping pace with the burden.

2.4. NP role

In 1965 Dr Loretta Ford (registered nurse) and Dr Henry Silver (physician) first proposed the NP role at the University of Colorado, this was the genesis of a new identity and expanded role for nurses (Asubonteng, McCleary, & Munchus,

Please cite this article in press as: Cashin, A., et al. The internationally present perpetual policy themes inhibiting development of the nurse practitioner role in the primary care context: An Australian—USA comparison. *Collegian* (2016), http://dx.doi.org/10.1016/j.colegn.2016.05.001