Advancing nurse leadership

ACN

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Dear Professor Robinson

Submission to the Medicare Benefits Schedule (MBS) Review Taskforce Consultation

Please find attached a submission to the Department of Health's Medicare Benefits Schedule (MBS) Review Taskforce Consultation. Should you require any further information or clarification of any issues addressed in this submission by the Australian College of Nursing (ACN) please do not hesitate to contact me.

ACN looks forward to the outcomes of this inquiry.

Yours sincerely

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Acting Chief Executive Officer

6 November 2015

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Introduction

The Australian College of Nursing (ACN) welcomes the opportunity to provide a submission to the Department of Health Medicare Benefits Schedule Review Taskforce Consultation. ACN is supportive of the Government's intention to review the MBS, as part of a broader *Healthier Medicare* initiative. In particular, ACN believes that a number of significant opportunities exist to implement reform to improve outcomes for patients. Broadly, the review presents opportunities to incorporate a greater recognition of nurses' contribution to primary health care and to unlock the unrealised potential within the nursing workforce. In particular, a more significant emphasis should be placed on nurse practitioners (NP), an existing role that is regulated and legislated across Australia to provide entire episodes of care to populations in a wide variety of settings, including primary care across the continuum of peoples' lives.

The demand for primary health care in Australia is increasing as a result of our ageing population and increasing incidence of chronic disease. There is therefore some urgency to rethink the way care is delivered in order to improve outcomes, reduce health costs and prevent unnecessary hospitalisation.[1][2][3] In Australia, as is common in many countries, general practitioners are key providers of primary care services[4], however primary health care extends beyond the scope and capability of the GP workforce. The answer to improved primary health care lies in better utilisation of the range of other health professions and realisation of the potential of the NP role and other nurses to deliver primary health care. The MBS is currently structured and

[1] Department of Health and Ageing. 2009. Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy. Commonwealth of Australia, Canberra.
[2] Department of Health and Ageing (2010) Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy. Commonwealth of Australia, Canberra.
[3] Finlayson M. et al. 2012. The impact of funding changes on the implementation of primary health care policy. *Primary Health Care Research & Development*, 13 (2), pp. 120–129.
[4] Carter M. et al. 2015. Meeting Australia's Emerging Primary Care Needs by Nurse Practitioners. *The Journal for Nurse Practitioners*, 11 (6), p. 647.

administered in such a way that it does not recognise or support the full potential of a range of health professions to address the expanding community need for services.

MBS Reform Opportunities

ACN believes that MBS reform must support implementation of transparent and accountable funding mechanisms that are developed to increase access to health care and encourage and support a person-centred and outcomes-based approach to care delivery. In contrast, the current processes and task driven mechanisms that are perpetuated through the MBS are leading to entrenched inefficiencies. ACN also believes that refinement of these funding mechanisms must ensure that equal services are equally remunerated, regardless whether they are provided by general practitioners, nurses or other health professionals. Service subsidisation must be based on patient need and/or outcomes achieved and not restricted by type of provider. For example, Medicare broadly recognises the need for collaboration in the prevention and management of chronic disease in primary care through the chronic disease management (CDM) MBS items. These items currently only subsidise services initiated, provided by or coordinated by GPs such as occurs with the GP Management Plan (GPMP) (item 721); coordinating the preparation of Team Care Arrangements (TCAs) – involving a team of at least three health professionals or care providers (item 723); reviewing a GPMP (item 732); coordinating a review of TCAs (item 732); contributing to, or reviewing, a multidisciplinary care plan that has been developed by another provider (item 729); and organising and coordinating, or participating in, a multidisciplinary case conference (items 735, 739, 743, and 747, 750, and 758, respectively). However, the rules governing these items only allow payments to GPs. Other health professionals such as nurses and allied health providers do not get reimbursed for these multidisciplinary care meetings despite the critical role they often play in achieving better outcomes for their patients.

Of particular concern to ACN is that the current CDM MBS items lack a clear incentive to keep people well and engaged in their health care. CDM MBS items focus on processes and tasks rather than outcomes, which creates the risk of approaches to care being merely 'tick the box' exercises with little encouragement for the health professional to oversee the plan's implementation and evaluate the consumer response and outcomes.

Reimbursement

Fees for services provided by non-GP health care professionals such as privately practicing nurse practitioners and allied health providers are not reimbursed through MBS as they are for GPs. However, these same health professionals commonly practice in situations and settings that are lacking GPs, such as rural and remote Australia improving access to care and reducing service gaps. Nurse practitioner practices are frequently established in areas where gaps exist for vulnerable populations. Examples are aged care, Aboriginal health, mental health, palliative care and drug and alcohol services. Such practices are often not financially sustainable due to inadequate subsidisation of the clinical service through the MBS.

Nurse practitioners' inability to initiate the wide range of subsidised diagnostic imaging and pathology services required to support care, results in consumers being charged the full, unsubsidised cost of these items, or being unnecessarily referred to another provider in order to access an MBS subsidy. This in turn may lead to a clinically unjustified duplication of services at increased cost to the MBS.

Savings Through More Effective Workforce Utilisation

There is clear opportunity to improve consumer access to primary health care services and create greater efficiency in the health system if a health professional with the right expertise delivers a specified service. Matching the health practitioners' expertise to the care required ensures such greater efficiency. Making subsidisation available to consumers for services provided by general practice nurses, specialist nurses, and nurse practitioners would greatly improve the efficiency of the MBS and the primary health care system. Reimbursement through the MBS should be commensurate with nurses' skills and expertise, recognising the value they add to the health system. Evidence suggests that specialist nurses can generate significant savings for the health system by reducing avoidable hospital admissions and length of stay. In the UK, for instance, where Parkinson's disease community nurses have been a prominent feature of their primary health care sector for more than 20 years, it was estimated that over a 12 month period around 2007, that *one*

Parkinson's nurse saved the health system close to $700,000[5] that could have been utilised elsewhere.[6] This example highlights that greater utilisation of nursing roles can contribute to significant savings through reducing unnecessary specialist appointments and unplanned hospital admissions and inpatient days spent in hospital.

Additional evidence demonstrates that clinical outcomes for people with other conditions such as diabetes or colorectal cancer either remain the same, or are improved, when being treated in a nurse clinic (by a specialist nurse or nurse practitioner) compared with standard treatment in a general practice.[7,8]In many cases, consumer satisfaction is also higher with this attributed to nurses spending more time in monitoring the health needs of patients, improving health literacy, and taking a preventative and responsive approach in tailoring an individual's care while delivering a better response to the patient's needs, values, and preferences.[9,10]

MBS and Nurse Practitioners

Despite the known benefits and potential of the nursing profession to contribute value to both consumers and the health system, nurses remain unduly restricted and largely undervalued within current MBS arrangements. Privately practicing nurse practitioners, who provide safe, high quality care in the prevention and management of disease,[11] are not enabled to fully practice as eligible providers within the MBS or PBS

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[5] This figure has been adjusted for the UK inflation rate and then converted GBP to AUD based on the exchange rate on 3 November 2015.

[6]Parkinson's UK. 2011. Parkinson's Nurses – affordable, local, accessible and expert care. Parkinson's UK, July 2011, p.4.

[7] Denver E. et al. 2003. Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with Type 2 Diabetes. *Diabetes Care,* 26(8), pp. 2256-2260.

[8]Morcom J. et al. 2005. Establishing an Australian nurse practitioner-led colorectal cancer screening clinic. *Gastroenterology Nursing,* 28(1), pp. 33-42.

[9]Jarman B. et al. 2002. Effects of community based nurses specialising in Parkinson's disease on health outcome and costs: Randomised controlled trial. *British Medical Journal,* 324:1072.

[10]Kinnersley P. et al. 2000. Randomised controlled trial of nurse practitioner versus general practitioner care for patients request "same day" consultations in primary care. *British Medical Journal*, 320(7241), pp. 1043-1048.

[11]Kinnersley P. et al. 2000. Randomised controlled trial of nurse practitioner versus general practitioner care for patients request "same day" consultations in primary care. *British Medical Journal*, 320(7241), pp. 1043-1048.

(Pharmaceutical Benefits Scheme) unless they have a formal collaborative arrangement with a medical practitioner. This requirement is not imposed on any other profession.

The structure of MBS funding for nurse practitioners links them insufficiently into the health care funding system and thus further restricts the value nurse practitioners can generate. For example, patients cared for by nurse practitioners (NPs) are restricted to subsidisation for only time-tiered face-to-face, one-on-one consultation items and a limited number of subsidised diagnostic imaging and pathology services. There is no entitlement to subsidisation for procedures undertaken by NPs. Likewise consultations with NPs via telehealth or the entire suite of chronic disease management items entailing collaboration with other health care team members, such as in case conference participation (something that GPs are remunerated for) are not funded. NPs are also unable to refer consumers for MBS subsidised allied health services nor are they remunerated for outreach clinical services (significantly restricting access for vulnerable populations including the aged and Aboriginal communities, consumers with mental health conditions and other groups who may not access mainstream health services).

The rate of subsidy for NP items is not commensurate with the high level of expertise of NPs or that of other professionals at similar levels of specialisation who receive rebates for services provided. Rather, the rates are well below those for other health professionals. For example, a nurse practitioner is remunerated through Medicare for level A, B, C, and D consultations at $8.20, $17.85, $33.80, and $49.80,[12] respectively, then subsidised at 85% of the maximum rebate when compared with the 100% rebate available for GPs. For the same consultation times, a GP receives rebates of $16.95, $37.05, $71.70, and $105.55[13]. In other words, the services of general practitioners are subsidised at a rate more than double that of a NP, for a similar level of service provision.

Such inequity in the MBS patient benefit is found across settings and different specialties in the health care system. Mental health nurse practitioners (MHNPs), for instance, are entitled to the level D (40+ min) consultation as a maximum, which is paid at $49.80. This is despite face-to-face consultations lasting for

[12] Factoring in the fact that NPs are only reimbursed for 85% of the MBS item, compared to GPs' 100%.
[13] These remuneration figures are for a vocationally registered GP.

between 60-90 minutes. Reimbursement arrangements for clinical psychologists under Better Access, recognise the important element of time in quality mental health care, where 50+ min items are available. Clinical psychologist MBS items are valued at $84.80 (30+ min) and $124.50 (50+ min) ($145.65 if the consult occurs outside of a consulting room). Not only does this inequity degrade the value that MHNPs represent within the health system, it also undermines the financial viability of running a private practice.

These existing arrangements for funding primary health care are at odds with the government's intent to better respond to the health needs of consumers. An effective and efficient response to the health care needs of the Australian population unequivocally requires recognition of the actual and potential contribution of all health care providers in the provision of efficient, effective, and sustainable health care. This recognition is of particular importance if Australia is to be able to meet the future demands of health care delivery. ACN is of the view that until wider funding reform is achieved, the Australian Government should increase the number and value of nurse practitioner and other nurse Medicare items. Further the range of subsidised services such as colposcopy that NPs are able to provide and refer consumers to should be extended. Extending the range of subsidised services would (1) increase access to disease prevention and management services for consumers; (2) reduce unnecessary duplication of MBS subsidised services; (3) reduce health care costs to consumers; and (4) adequately recognise the skills, expertise, and contribution that nurse practitioners and nurses widely make to the primary health system, and to the health outcomes of consumers.

Conclusion

ACN believes that the MBS review should seek to better understand the role, benefits and potential of all nurses across the system. The review should also seek to ensure that nurses are enabled to work to their full scope of practice and truly maximise the potential of their role. Funding systems should contribute to the development of a flexible high quality nurse workforce within Australia's future primary health care system.

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