Australian Nursing & Midwifery Federation

Submission to Medicare Benefits Schedule Review Taskforce Public Consultation Paper

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Introduction

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership which now stands at over 249,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Nurses and midwives together comprise more than half the total health workforce. They are the most geographically dispersed health professionals in this country, providing health care to people across their lifespan and in all socio-economic spheres.

The ANMF welcomes the opportunity to provide advice to the Medicare Benefits Schedule (MBS) Review Taskforce to guide its deliberations on improving the current system, consistent with evidence-based practice and best value for health care.

General comments

Nurses and midwives

Registered nurses and midwives are regulated health care professionals, who provide care in collaboration with other health professionals and individuals requiring care. Legislation and regulation guide nursing and midwifery practice. Registered nurses and midwives, as qualified registered health professionals, are accountable and responsible for their own actions.

Nurses and midwives are entitled to identify the care which they are educated, competent and authorised to provide. They are held accountable for their practice by the Nursing and Midwifery Board of Australia (NMBA), whose role is to protect the public, as is the case for all other regulated health professions.

As regulated health professionals, registered nurses and midwives are not 'supervised' nor do they provide care 'for and on behalf of' any other health care professional. Nurses and midwives acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups.

There are currently 268,634 registered nurses and 61,880 enrolled nurses registered with the NMBA[1], including a total of 1,248 nurse practitioners. There are 30,522 midwives registered with the NMBA including 182 eligible midwives and one midwife practitioner.

1.Nursing and Midwifery Board of Australia (NMBA). *Nurse and Midwife registrant data: June 2015*. Retrieved on 30 October 2015 from: http://www.nursingmidwiferyboard.gov.au

Universal health insurance

The ANMF has remained a staunch advocate of a universal health insurance coverage for all Australians since the introduction of Medibank in 1975, later revamped as Medicare in 1984. The philosophical underpinning of the nursing and midwifery professions is that all people, regardless of socio-economic status, should be able to access health care services appropriate to their needs. That is, access to services should always be based on clinical need and not on ability to pay.

As it is over 20 years since the current MBS was introduced the ANMF agrees it is imperative all 5,769 MBS items be reviewed for their relevance and contemporary evidence base for health care practice. The ANMF considers there are parts of the MBS that are out-of date and that the language focusses on medical practitioners, and in particular the General Practitioner (GP) as the gatekeeper. This must now be amended to remove the GP gatekeeper role and to be inclusive of the range of other health professionals, including nurse practitioners and eligible midwives, involved in the provision of comprehensive primary health care.

The review process is heavily medical practitioner focussed. Despite the fact that nurse practitioners and eligible midwives have access to the MBS in their own right, they are not represented on the MBS Review Taskforce. This is an unacceptable oversight. Nurses and midwives are not even mentioned in the listing of who has access to the MBS. This listing needs to reflect current practice.

It is essential that nurse practitioners and eligible midwives are represented on the Clinical Committees established for the MBS Review. Any changes proposed to MBS item numbers for nurse practitioner and eligible midwife services must involve consultation with these expert nurses and midwives and the professional organisations that represent their interests, namely the ANMF, ACNP, ACN and ACM.

With regard to the use of the MBS, the ANMF considers there is valuable data sitting in the MBS system which could be used for population health research purposes (de-identified), and also for quality improvement purposes and review of practice. This data should be used actively to guide quality health practice, not just medical practice. If this additional information were routinely collected and available (de-identified) for analysis, it could provide evidence to improve health policy in a range of ways—for example, better evidence to inform future reviews, the ability to identify patient groups who should be receiving additional care, or the ability to earlier identify the emergence of an epidemic.

In terms of what can be done to reduce unexpected variation in the MBS items claimed for similar services, we suggest clear unambiguous descriptors of the MBS items and explanatory notes with appropriate education support, for effective implementation.

The ANMF considers it is essential this opportunity for reform of the MBS does not perpetuate more of what we have now. We need changes which will enable innovation. With the increasing age of our population and increasing rates of chronic and complex disease, we need to re-think the way health care is delivered. Nurse practitioners and eligible midwives are key to this change, and the system needs to provide the option for them to contribute their intrinsic care which is delivered in the way that best meets the expectations and needs of individuals and the community.

Payment models

The current systems for health funding in Australia create serious barriers for nurse practitioners and eligible midwives and limit their effectiveness in terms of equity, access and value for money in health care delivery. In most instances, the community does not have much input or control in relation to health strategies that directly affect them. The models of promotion, prevention, chronic and complex condition care and treatment are not always based on the best available evidence. This leads to discrepancies in their efficiency and cost effectiveness. The current care modalities do not necessarily provide for positive outcomes for people and their communities; and sustainable, replicable service delivery remains a challenge.

The ANMF strongly supports funding models which provide for positive health outcomes for communities through sound health policy designed to meet population needs. Funding for services, programs, care and treatment must be based on the health needs of the community and be designed to promote the goals of primary health care enabling the promotion of health, maintenance of health, and continuity of care for chronic and complex conditions management; and, funding must allow for the involvement of a range of health care professionals in the care. This model allows for a person to be seen by the right health professional for their needs, in an appropriate place, at the right time - that is, a 'needs' driven funding model, not one driven by a particular health care professional.

Providing a blended payment system (mixing fee-for-service, pre-payment and payment for performance with salaried arrangements) in primary health care, to facilitate team based care, is supported by the ANMF as a means to achieve an integrated model of care and optimal health outcomes. Furthermore, the ANMF maintains the key to providing better access for the community to primary health care services is the development of funding models in which the funding maximises services directly to the consumer (the funding follows the person) and not solely to the provider (as in the current fee-for-service model). This allows for nurse practitioners, eligible midwives, other nurses and midwives, as well as health professionals, to engage more meaningfully in care management (for example, chronic disease management) without the flawed arrangement of funding being tied to the GP, who may only see the person briefly during an episode of care, if at all.

Nurse and midwives, as well as some other health professionals, should have direct access to funding to cover all aspects of their primary health care practice without the process being 'for and on behalf of' a third party. A variety of responsive forms of service delivery, provided by a range of health professional providers, including nurses and midwives, must be available to meet the needs of all people, including those with special needs such as cultural or language barriers, intellectual disability and chronic and complex conditions.

The ANMF contends that where health professionals work in teams there is effective service delivery with better outcomes for the community. Where there is no, or fractured, communication between health professionals, information and service delivery gaps occur, to the detriment of the care recipients. When the full range of health professionals is not used, for example within primary health care, this decreases choice for consumers of the services and more importantly decreases their access to care.

Specific Comment

The ANMF notes the Taskforce is looking for guidance on the following two essential issues:

- Examples where the MBS seems to be failing to support delivery of best value healthcare,
- Recommended improvements to the surrounding 'rules', processes and systems that support the MBS.

Our response provides advice on these two broad issues rather than addressing the specific questions posed in the Taskforce consultation paper.

In brief, the ANMF considers the review is necessary to contemporise the MBS to:

1. remove the out-moded item based funding model of nurses in general practice providing services 'for and on behalf' of the medical practitioner; and
2. more appropriately accommodate the services provided by nurse practitioners and eligible midwives.

Nurses in general practice

According to the Australian Institute of Health and Welfare (AIHW) there are currently 10,613 nurses working in General Practice[2]; and, 25,702 general practitioners (GPs)[3] working in General Practice. The numbers of nurses employed in the Australian General Practice environment has risen exponentially over the past decade as a result of a positive policy environment and enhanced funding of nursing services[4]. Between 2003 and 2012, the percentage of General Practices employing a nurse rose from 40%[5] to 63.3%[6]. However, this rapid workforce growth has occurred in a somewhat ad hoc manner as a response to various funding schemes, rather than being a carefully planned workforce development[7]. This has raised a number of challenges for the nursing profession around the role of the nurse in General Practice, the nurse's scope of practice and continuing professional development opportunities[8].

The ANMF National Practice Standards for Nurses in General Practice, released in 2014[9], funded by the Australian Government Department of Health, assist in highlighting the potential scope of practice for a nurse employed in General Practice, for employers and practice managers.

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2 Australian Institute of Health and Welfare. *Nursing and midwifery workforce 2014*. Canberra: AIHW, 2015.
3 Australian Institute of Health and Welfare. *Medical workforce 2013*. Canberra: AIHW, 2015.
4 McKenna, L., Halcomb, E., Lane, R., Zwar, N., and Russell, G. *An investigation of barriers and enablers to advanced nursing roles in Australian general practice.* Collegian (2015) 22: p. 183-189.
5. Australian Divisions of General Practice Ltd. *National practice nurse workforce survey 2003*. 2003 Available from: http://generalpracticenursing.com.au/__data/assets/pdf_file/0006/15378/National-Practice-Nurse-Workforce-Survey-2003.pdf .
6. Australian Medicare Local Alliance. *General Practice nurse national survey report. 2012* Available from: http://amlalliance.com.au/__data/assets/pdf_file/0003/46731/2012-General-Practice-Nurse-National-Survey-Report.pdf
7. Halcomb, E.J., E. Patterson, and P.M. Davidson, Evolution of practice nursing in Australia. *Journal of Advanced Nursing*, 2006. 53(3): p. 376-390.
8 Halcomb, E.J., et al., The evolution of nursing in Australian general practice: a comparative analysis of workforce surveys ten years on. *BMC Family Practice* 2014. 15(52): p. http://www.biomedcentral.com/1471-2296/15/52.
9 Australian Nursing and Midwifery Federation. 2014. *ANMF National Practice Standards for Nurses in General Practice*. Available from: http://www.anmf.org.au/documents/National_Practice_Standards_for_Nurses_in_General_Practice.pdf

Funding for Australian General Practice services is predominately a fee-for-service model, with Practices operating as small businesses or within larger corporate chains. While the national universal medical insurance scheme (Medicare) provides remuneration to the Practice for each item of service, increasingly, consumers are being required to pay a gap fee to the Practice. In 2011-12, almost $5.6 billion dollars was spent by the Federal Government on services provided by doctors and nurses in General Practice[10].

Prior to 2012, the MBS provided specific item numbers for the delivery of nursing services, such as, cervical smears, immunisations and wound care, provided 'for and on behalf of' a general practitioner. For each occasion of nursing service, remuneration was provided to the Practice from Medicare. This funding model significantly impacted on the services that were delivered by nurses in General Practice[11]. On 1 January 2012 the Practice Nurse Incentive Program (PNIP) was implemented[12]. This program provides incentive payments to accredited General Practices to offset the employment of a registered nurse and enrolled nurse[13]. The amount of incentive payment received by a Practice is based on its Standardised Whole Patient Equivalent (SWPE) value and the number of hours worked by nurses[14]. This incentive aims to support an "enhanced role for nurses working in General Practice" as it is not tied to the delivery of any specific services[15]. (The ANMF notes an evaluation of the PNIP, completed more than 12 months ago, has still not been made publically available).

The ANMF argues for the removal of the current restriction in the PNIP funding for the numbers of nurses and midwives employed being tied to the number of GPs in a practice, in order to access payment for a nurse/midwife. The PNIP funding of nurses and midwives in general practice needs to be uncoupled from the GP (that is, deconstruct the GP : Nurse/Midwife ratio). This would enable more nurses or midwives to be employed within general practice and better meet community needs.

Of particular relevance to the MBS review is the ANMF's request for the abolition of the remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice 'for and on behalf' of the GP, or 'under the supervision' of the GP. These item numbers are for: health assessments, chronic disease management, antenatal care, management plans, team care arrangements, spirometry, ECG, and telehealth (10986, 10987, 10997, 16400, 10983, 10984, 11506, 11700, 701-707, 715, 721, 723, 722).

The retention of some MBS item numbers has meant that the intent of the PNIP to enhance the role of nurses working in General Practice has not been fully achieved. Funding remains tied to specific services only. This in turn perpetuates a model whereby employers, usually GPs, or practice managers, direct nurses to focus care only on those activities that can be billed through Medicare.

Instead of continuing with these MBS item numbers, the amount of funding for the PNIP should be significantly increased. This would allow nurses and midwives to work to their full scope of practice - the original intent of the PNIP funding.

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10 Australian Government Department of Health and Ageing. *Medicare Statistics - June quarter 2012, Group BA tables.* 2012 Available from: www.health.gov.au/internet/main/publishing.nsf/Content/medstat-jun12-tablesba

11 Halcomb, E.J., et al., Nurses in Australian general practice: implications for chronic disease management. *Journal of Nursing & Healthcare of Chronic Illnesses*, 2008. 17(5A): p. 6-15.

12 Medicare Australia. *Practice Nurse Incentive Program Guidelines*. 2012 [cited 2014 November 4]; Available from: http://www.medicareaustralia.gov.au/provider/incentives/files/9689-1208en.pdf

13 Ibid.

14 Ibid.

15 Ibid. p. 3.

In Australian General Practice, registered nurses and enrolled nurses work together in complementary roles within the nursing team. While all nurses are accountable for their own individual practice[16],[17] the NMBA requires the practice of an enrolled nurse is supervised by a registered nurse[18]. This supervision arrangement is required regardless of whether a general practitioner is in attendance or not. Having a named registered nurse to provide supervision and appropriate delegation of nursing care is essential to both meeting the requirements of practice and maintaining patient safety. The level of supervision required for enrolled nurse practice is dependent on a range of factors, including the knowledge, skills and competence of the individual enrolled nurse, the acuity of the patient and the nature and complexity of the care being provided[19]. Supervision of the enrolled nurse by the registered nurse can either be direct, where the registered nurse is physically present and works together with the enrolled nurse, or indirect where the registered nurse is readily contactable during the enrolled nurse's working hours but does not directly observe the care as it is being provided[20].

Nurse practitioners and eligible midwives

We concur with Consultation Paper which states (page 15) that:

> *The overall objective of the Australian health system is that people have access to affordable, high-quality health care. The MBS has a key role to play in achieving this objective.*

The ANMF maintains this encapsulates our reason for wanting to see the MBS being more accommodating to nurse practitioners and eligible midwives, to improve access for all sectors of the community to evidence-based care they can afford.

Nurse practitioners

The nurse practitioner role is now well established in Australia with research highlighting the diversity or roles across the country. The nurse practitioner role is differentiated by their expert practice in clinical assessment, prescribing, referral and diagnostics. These broader practice modalities are enshrined in state and territory legislation. While there are 1248 endorsed nurse practitioners in Australia[21], only around half of these expert nurses are employed in nurse practitioner positions and even less are practising to the full scope of their role.

Some of the restrictions on nurse practitioner practice are:

- the lack of positions;
- the lack of viable employment opportunities in private practice;
- inability to claim after-hours item numbers when providing services;
- restrictions on ordering of pathology and diagnostic tests and in particular, imaging;

16 Nursing and Midwifery Board of Australia, *National competency standards for the registered nurse*. 2006: Melbourne, Victoria.
17 Nursing and Midwifery Board of Australia, *National competency standards for the enrolled nurse*. 2002. Melbourne, Victoria.(current). Revised in 2015 to: *Standards for Practice: Enrolled Nurses*. 2016.:Effective 1 January 2016. Available from: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx
18 Ibid previous two references.
19 Australian Nursing and Midwifery Federation. 2014. *ANMF National Practice Standards for Nurses in General Practice*. Available from: http://www.anmf.org.au/documents/National_Practice_Standards_for_Nurses_in_General_Practice.pdf
20 Ibid.
21 Nursing and Midwifery Board of Australia, *Nurse and Midwife Registration Data*. June 2015. Available from: http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

- the inability for patients to receive certain subsidised medicines if prescribed by a nurse practitioner (as distinct from a medical practitioner);
- restriction to PBS prescribing for continuing therapy only for many PBS medicines; and
- inadequate rebates from MBS for nurse practitioner services.

These factors severely restrict nurse practitioner practice and reduce patients' access to affordable, high quality health care.

We maintain nurse practitioners should be used more extensively within multidisciplinary teams across the spectrum of primary health care services, in all geographic locations. Nurse practitioners can, and do, undertake important roles in providing improved access to primary health care services and chronic disease management, to individuals and communities. Consumers thus have access to a broader range of health professionals, and to those who are particularly skilled in, and have time, to deal with chronic and complex conditions.

In order to facilitate access to nurse practitioners a number of structures need to be put in place. Primarily, nurse practitioners in the public sector need to be given access to MBS to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals including allied health, when required.

That is, we request that nurse practitioners in the public sector be given 'request and refer' access to the MBS, just as is the case for medical interns. So too, there should be a substantial increase in the payment for MBS items for nurse practitioners in private primary health care settings, including mental health, to enable them to establish viable and sustainable practice. Nurse practitioners are now well established in Australia, and have already proven their value to our health and aged care systems. Accessibility to their range of care modalities, should be facilitated and broadened to better meet population health needs.

The ANMF considers the following issues are essential for funding for nurse practitioners:

- allowing nurse practitioners to be eligible, as registered nurses, to PNIP funding;
- funding for designated salaried nurse practitioner positions in the public sector, including in small rural and remote communities;
- access to 'request and refer' MBS provider numbers for nurse practitioners in the public sector, as is the case for medical interns;
- a substantial increase in the payment for MBS items for nurse practitioners in private practice to enable them to establish viable and sustainable practice;
- recurrent incentive funding for nurse practitioners in private practice to work in areas of designated District Workforce Shortage;
- infrastructure funding for nurse practitioners to establish private practice;
- allowing nurse practitioners to employ other nurses under the PNIP in the same way as GPs; and
- provide nurse practitioners with MBS item numbers for after-hours services and procedural services (similar to GPs).

The ability for nurse practitioners in primary health care to work to their full scope of practice is vital. Nurse practitioners need to be recognised primary health care professionals, able to provide independent services under appropriately remunerated MBS item numbers.

Eligible midwives

As previously stated, there are now 182 eligible midwives in Australia[22]. The role of eligible midwife is differentiated from other midwives by their expert practice in the provision of pregnancy, labour, birth and postnatal care, across the continuum of midwifery care. The continuum of midwifery care for the eligible midwife incorporates: antenatal care, intra partum care and postnatal care for women and their infants, and includes clinical assessment, exercise of clinical judgement, planning, implementation, monitoring and review, responding to maternity emergencies, assessment and care of the newborn infant; and, prescribing schedule 2, 3, 4, and 8 medicines (in accordance with relevant state or territory legislation), making referrals to other health professionals, and ordering diagnostic investigations appropriate to their scope of practice.[23] The term 'eligible' denotes the fact these midwives can apply for a Medicare provider number so the women for whom they provide care can obtain Medicare rebates, and prescribe certain Pharmaceuticals Benefits Scheme (PBS) medicines. A privately practising (self-employed) eligible midwife can apply for a Medicare Provider Number so that women in their care can claim Medicare rebates for the midwifery care they receive.

Similar to nurse practitioners, eligible midwives also face barriers to practicing to their full scope, again limiting their practice and reducing women's access to affordable, high quality health care. These barriers are mirrored across the two professions with eligible midwives facing additional obstacles in obtaining professional indemnity insurance to cover the full scope of their practice. Eligible midwives have access to only one professional indemnity insurance scheme: Commonwealth-subsidised professional indemnity insurance through MIGA (Medical Insurance Group Australia) which covers antenatal and postnatal care, and birth services the eligible midwife provides in hospital to their private clients. Eligible midwives may also encounter difficulties in establishing legislated collaborative arrangements with medical colleagues required to engage in private practice, thus forming another barrier to practicing to their full scope.

The ANMF considers the following issues are essential for funding for eligible midwives:

- funding for designated salaried eligible midwife positions in the public sector, including in small rural and remote communities;
- access to 'request and refer' MBS provider numbers for eligible midwives in the public sector, as is the case for medical interns;
- a substantial increase in the payment for MBS items for eligible midwives in private practice to enable them to establish viable and sustainable practice;
- recurrent incentive funding for eligible midwives in private practice to work in areas of designated District Workforce Shortage; and
- infrastructure funding for eligible midwives to establish private practice.

22 Nursing and Midwifery Board of Australia, *Nurse and Midwife Registration Data*. June 2015. Available from: http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx
23 Nursing and Midwifery Board of Australia. 2013. *Eligible midwife registration standard*. Available from: http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

Recommendations to the MBS Review Taskforce

The Australian Nursing and Midwifery Federation recommends that:

1. *The remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice 'for and on behalf' of the GP, or 'under the supervision' of the GP, be abolished. These item numbers are for: health assessments, chronic disease management, antenatal care, management plans, team care arrangements, spirometry, ECG, and telehealth (10986, 10987, 10997, 16400, 10983, 10984, 11506, 11700, 701-707, 715, 721, 723, 722). That this funding be replaced by increased funding into the Practice Nurse Incentive Payment (PNIP) Fund, to facilitate nurses in general practice working to their full scope.*

2. *The PNIP funding for nurses and midwives employed in general practice be uncoupled from the GP/s.*

3. *Nurse practitioners be eligible, as registered nurses, to PNIP funding;*

4. *Nurse practitioners are able to employ other nurses under the PNIP in the same way as GPs;*

5. *There be a substantial increase in the payment for MBS items for nurse practitioners and eligible midwives in private practice to enable them to establish a viable and sustainable practice.*

6. *Nurse practitioners and eligible midwives be granted more scope to order diagnostic investigations (particularly imaging), initiate prescribing and refer to other health professionals, under MBS rules.*

7. *There be recurrent incentive funding for nurse practitioners and eligible midwives in private practice to work in areas of designated District Workforce Shortage;*

8. *There be infrastructure funding for nurse practitioners and eligible midwives to establish private practice;*

9. *There be funding for designated salaried nurse practitioner and eligible midwife positions in the public sector, including in small rural and remote communities;*

10. *There be access to 'request and refer' MBS provider numbers for nurse practitioners and for eligible midwives in the public sector, as is the case for medical interns in the tertiary setting.*

11. *Nurse practitioners be provided with MBS item numbers for after-hours services and procedural services (similar to Vocationally Registered and Non-Vocationally Registered GP workforce) to provide access to timely health care.*