18/206

16 April 2019

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Professor Bruce Robinson
Chair, MBS Review Taskforce

By Email: mbsreviews@health.gov.au

AMA response to the Report from the Nurse Practitioner Reference Group

The AMA appreciates the opportunity to respond to the report from the Nurse Practitioner Reference Group. The AMA response seeks to safeguard a primary health care system equipped to deliver the right care, at the right time, in the right place, and in so doing ensure better health and health care outcomes for all Australians.

Key Points:

- The AMA does not support the removal of the requirement for collaborative care in the provision of services by Nurse Practitioners (NPs).
- The AMA does not support independent access to the Medical Schedule of Services for NPs.
- The AMA supports the role of the General Practitioner as the key provider of primary care to patients and encourages the collaborative role of NPs both in primary care and other specialist medical practice to extend value in the health care system.
- The AMA would support practices being funded through an incentive or funding stream outside of the MBS to integrate NPs into their health care team and support NPs functions within the team.

General comment

General practice is the cornerstone of successful primary health care, which underpins population health outcomes and is key to ensuring we have a high-quality, equitable and sustainable health system into the future.

A successful primary health care system should also:

- Provide cost-effective, community-based care, and in doing so appropriately minimise hospital-based care;
- Act as both an enabler and gateway to other services to ensure they are provided in a timely way but only when needed; and
- Coordinate care between different health providers and different parts of the health care system, ensuring a seamless, integrated, effective experience for the patient and minimising costly fragmentation, duplication or gaps in care.

General practice provides continuing, comprehensive and co-ordinated, culturally sensitive, inter-generational holistic health care to individuals and families in their communities. It is

underpinned by rigorous scientific medical training and the ability to apply the evidence appropriately in community settings. All these elements place general practice at the centre of an effective primary health care system.

GPs are the highest trained general health professional with a minimum of 10 to 15 years training. A GP's skills encompass: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling. GPs are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom or health concern.

Other health professionals, such as nurse practitioners (NPs), may be able to make a limited diagnosis of a specific illness or injury, but they are not trained in the total health care of the whole person. They are trained in specific areas with specific levels of knowledge and experience and are not able to make an holistic assessment of the patient.

Quality general practice adopts the Quadruple Aim framework[1], an approach to optimising health system performance by:

- Pursuing improvements in population health, primarily through,
- Enhancing the patient experience of care,
- Reducing the per capita cost to the health care system, and.
- Improving the work life of health care providers is crucial in the achievement of the first three aims.

AMA's key principles regarding NP access to the MBS are:

- The importance of patient access to a medical diagnosis,
- The need for patient care to be led and properly coordinated by a medical practitioner,
- The importance of structured reporting lines and well-defined roles within a team, and
- That key parts of patient care can be delegated to other health professionals, provided they are appropriately skilled and robust protocols are in place.

In considering the recommendations of the NPRG the AMA notes that while there is evidence to support greater clinical autonomy for nurses, such research is undertaken in environments (i.e. hospitals) where there are established nurse-driven protocols which provide a path for the delegation of clinical authority[2] under a medical oversight framework.

Furthermore, the AMA notes Salisbury's and Munro's review of nurse-led walk in centres which highlights that while:

> "There is increasingly strong research evidence that nurses working in a general practice setting can safely and effectively manage minor illness. It is important to note that this evidence relates mainly to nurse practitioners who have received extended training in the assessment and management of minor illnesses, and who are working

[1] Bodenheimer, T and Sinsky, C From Triple to Quadruple Aim: *Care of the Patient Requires Care of the Provider*, Annals of Family Medicine vol.12 no. 6 573-576, Nov/Dec 2014

[2] Rao, Aditi D et al. "Better Nurse Autonomy Decreases the Odds of 30-Day Mortality and Failure to Rescue" *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing* vol. 49,1 (2016): 73-79.

in an environment where they are closely supported by medical colleagues. It does not necessarily follow that nurses without nurse practitioner training and who work independently of doctors can provide a similar standard of care in a different environment.[3]

Response to Recommendations:

The AMA notes the four themes that the Reference Groups recommendations are organised into:

- Supporting comprehensive and coordinated care for people with long-term health conditions and Aboriginal and/or Torres Strait Islander peoples,
- Enabling nurse practitioner care for all Australians,
- Addressing system inefficiencies caused by current MBS arrangements (Section 5.4), and
- Improving patient access to telehealth services (Section 5.5).

Collaborative arrangements essential

The AMA considers that NPs have a contribution to make to the quality and continuity of patient care within the primary care sector where they work in collaboration with medical practitioners, preferably within the confines of an integrated primary health care team working in a general practice medical home or a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

While the AMA recognises, the role NPs may play as part of an integrated primary health care team, GPs are the nation's preferred primary care provider, with 84% of Australians having seen a GP within the last 12 months[4]. Rather than looking for solutions that would undermine the role of general practice and the quality of care, the MBS Taskforce should be seeking to fortify general practice because, as the World Health Organization has identified, the populations in those countries with strong general practice have:[5]

- Lower all cause morbidity (lower rates of ill-health) and mortality,
- Better access to care by all members of the community,
- Lower rates of people being readmitted to hospital after treatment,
- Fewer consultations with consultant specialists,
- Less use of emergency services[6], and
- Better detection of adverse effects of medication interventions.

The key attributes of patient-centred medical home[7] are:

[3] Salisbury, C. and Munro, J. (2003) Walk-in centres in primary care: a review of the international literature. British Journal of General Practice, 53 (486). pp. 53-59. ISSN 0960-1643

[4] Australian Bureau of Statistics. *Patient Experiences in Australia: Summary of Findings, 2017-18*

[5] World Health Organization, The world health report 2008: Primary health care now more than ever, WHO, Geneva, 2008.

[6] O'Malley AS, *After-hours access to primary care practices linked to lower emergency department use and less unmet medical need*. Health Aff (Millwood), 2013. **32**(1): p.111

[7] https://www.aci.health.nsw.gov.au/nhn/patient-centred-medical-home-model/key-principles

- Continuity,
- Coordination,
- Comprehensiveness,
- Accountability,
- Accessibility, and
- Patient-centred

The majority of the recommendations of the NPRG do not align with these attributes because they seek to position NPs as an alternative provider to GPs rather than part of an integrated health care team.

The AMA strongly believes that it would be a retrograde step for the safety and quality of patient care and for the efficacy of service provision if the requirement for collaborative arrangements between NPs and medical practitioners were abandoned. It would lead to greater fragmentation of care and increased costs to the health system overall. Without a mechanism that ensures medically qualified clinical oversight the risk for disjointed care, misdiagnosis and missed diagnosis, inappropriate or unnecessary testing or referral, and delayed treatment is greatly enhanced. The collaborative requirement is not a system inefficiency in the AMA's view but is rather a mechanism for ensuring our health resources are used effectively.

The AMA notes the comment on page 44 of the NPRG report arguing against the collaborative arrangements on the basis that nurses and midwives are the only health professionals required by law to establish an arrangement with a medical practitioner in order to participate in the MBS. The AMA would reinforce that all other practitioner access to MBS items, be they specialists or allied health providers is on a referred basis.

Further, access to certain PBS medicines is also restricted for non-medical health practitioners unless they are in a collaborative arrangement with a medical practitioner. For example, the prescribing of ciprofloxacin and ofloxacin by optometrists may only occur in consultation with an ophthalmologist. In addition, the diagnosis of a glaucoma patient must be confirmed by an ophthalmologist in order for an optometrist to treat that patient. This is a requirement in the Optometry Board of Australia's *Guidelines for use of Scheduled Medicines* – which have been endorsed by Health Ministers and must be complied with as a condition of an optometrist registration.

<u>Stewardship</u>

From a stewardship perspective, ensuring the right care at the right time ensures greater efficiency and a more cost-effective health system. GPs (as do other medical practitioners) have an inherent responsibility to practice effective stewardship which is reinforced through the AMA Code of Ethics and the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia. Independent nurse practitioners would undermine this role as according to the Nursing and Midwifery Board of Australia Code of Professional Conduct of Nurses in Australia they are stewards of the resources of their employing organisations. NP access to MBS items without appropriate controls, such as a collaborative arrangement with a medical practitioner, in the AMA's opinion jeopardises the stewardship of health resources, as well as continuity and quality of care.

An integrated health care team spearheaded by the GP is best placed to improve health care provision for patients and to avoid fragmentation of care and additional costs to the health system. In addition, the GP is best placed to treat 90%[8] of presenting problems and to understand which preventive measures, diagnostic tests, allied health services, and specialist care would best meet the needs of their patients. For patients with chronic and complex disease, who require a range of multidisciplinary services, their GP and medical home is central to their care as both a facilitator and coordinator of their comprehensive care needs.

If NPs were granted unfettered access to the MBS it would likely facilitate the growth of corporate enterprises where medical practitioners are misguidedly replaced by nurse practitioners, fragmenting patient care and reducing the safety and quality of care. The growth of corporate after-hours service providers and the significant increase to health expenditure from the unprecedented surge in claims for MBS after-hours items, particularly urgent attendances,[9] when GPs responsibility for providing after hours care was diminished being a prime example of how this can occur.

MBS not the process for expanding scopes of practice

The AMA's view is that any action by a non-medical practitioner profession to expand its scope of practice must occur within the auspices and national governance framework of Health Ministers and the Australian Health Practitioners Registration Agency. This process ensures that:

- there are no new safety risks for patients;
- the change to scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking into account supervision costs.

The processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies; and
- there are documented protocols for collaboration with other health practitioners.

Any expansion of MBS items for nurse practitioners should only be considered after the above process has been undertaken, not before. Advocating for an expansion of MBS items for wound repair and skin cancer management as a way of expanding nurse practitioners' scope of practice is not an appropriate way to design the health care system to meet the future needs of the community.

[8] Cooke, G et al. *Common general practice presentations and publication frequency*. Australian Family Physician. Volume 42, No.1, January/February 2013 Pages 65-68

[9] Jackson, C. Review of the After Hours Primary Health Care, Report to the Minister for Health and Minister for Sport. 31 October 2014.

Enhancing NPs role within a collaborative environment

NPs working within a specialist medical practice, a general practice which operates as a medical home for its patients or an Aboriginal health service have significant potential to enhance service capacity and to support patient care in the primary care environment. Working within this framework would provide clinical oversight, while supporting the delegation of specific services in which the NP is skilled. This would ensure the safety and quality of patient care though collaboration with the medical practitioners within the practice, defined scopes of practice based on the NPs specific skills and training, and care provision protocols, particularly for when an issue needs to be escalated with a medical practitioner.

Fee for service items, outside of those already provided for, may not be the best mechanism for medical practices or health services to utilise NPs varied individual skills at this time. The AMA has significant concerns about providing access to items currently only accessible by medical practitioners to non-medically qualified providers. It would be more appropriate and more inline with the requirements for collaborate care and the key attributes of the medical home if practices were funded to engage NPs as part of the multidisciplinary health care team as part of a blended funding model to support comprehensive primary care. The Department of Veterans' Affairs Coordinated Veterans Care (CVC) payment an example of how practices can be supported to enhance the role of their practice nurses.

Supporting Aged Care, After Hours Access and Out of Clinic Visits

When working as part of an integrated health care team the AMA believes that with the current attendance items available to NPs and if further supported through blended funded model that supports medical practitioner led care that NPs could play a valuable role in delivering patient care. It would enhance the capacity of the practices or the health services they work with to deliver continuity, comprehensiveness and accessibility to patients, where clinically relevant in the after-hours period, disabled from attending rooms due to illness or with mobility issues, and to older people living in the community or residents of aged care facilities.

It would be irresponsible, however, to enable such services outside of a collaborative arrangement.

Older patients, for example, are often burdened with multiple and complex medical disorders that require the regular attention of medical practitioners, quality nursing care and allied health care professionals. Older people are more likely to present with:

- Degenerative diseases (osteoarthritis, joint pain, Parkinson's disease)
- Cardiovascular diseases (cardiac insufficiency, ischaemic heart disease)
- Metabolic diseases (diabetes, hypothyroidism)
- Urogenital (incontinence, vaginal prolapse, lower urinary tract symptoms)
- Neuropsychiatric/cognitive (delirium, dementia)[10].

[10] Royal Australian College of General Practitioners. CO16 Care of older people contextual unit.

The complexity of their care can be further complicated with the presence of undifferentiated symptoms, multisystem pathologies and sensory impairments. Holistic assessment and patient-centred clinical judgments around the care most appropriate for the patient require medical expertise.

Retention of current restrictions on diagnostic imaging

The AMA does not support the proposal to remove current restrictions on diagnostic imaging on the basis that the requirement for medical practitioner, typically GP, referral ensures there is two-way communication, collaboration with and clinical oversight of the NP. With evidence indicating that NPs order more tests than GPs[11] unlimited access to ordering diagnostic testing would have serious cost implications to Australia's health system, particularly if this was coupled with elimination of collaborative requirements.

The AMA can see no reason why a NP who is truly working within a collaborative environment would not be able to discuss the diagnostic needs of a patient with their collaborating medical practitioner. In a medical home environment this is what would occur, with the NPs notes on the patient readily available to the medical practitioner.

Access to procedural items

The NPRG recommendation to give NPs access to procedural items only further highlights the NPs quest to position themselves as independent and alternative providers to medical practitioners with no regard to the provision of quality care or patient safety.

There has been no demonstrated need for the removal of this restriction or evidence provided regarding NPs training in being able to provide these services, and can be viewed only as a blatant attempt to build a viable career for private practicing NPs.

The AMA's concerns around NPs independently undertaking procedures is further highlighted by the fact that a number of the items the NPRG has proposed NPs be given access to have been deleted from the MBS since 1 November 2016 (31205, 31201, and 31230) and 1 November 2017 (30067) respectively.

The AMA is also highly concerned by the proposal to allow NPs to claim items for the removal of benign and malignant skin lesions, particularly where these are related to areas of the body that are cosmetically sensitive or functionally critical such as the head and neck, the hand, the foot and the genitals. A poor outcome can result in a lifetime disfigurement or disability. For example, division of the accessory spinal verve with a skin cancer in the neck resulting in a weak shoulder, division of the marginal mandibular nerve resulting in a lip palsy or division of the lateral peroneal nerve resulting in foot drop and sensory disturbance.

Incomplete treatment of a malignant tumour makes subsequent appropriate management more difficult and risks the chance of complete cure. There are many of the skin lesion items applied for by the NPRG that a majority of GPs would not be comfortable performing and

[11] Hughes DR, Jiang M, Duszak R. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Intern Med.* 2015;175(1):101–107. doi:10.1001/jamainternmed.2014.6349

would refer to a specialist surgeon or dermatologist. Reducing the threshold to access these services does not serve patients best interests.

The AMA has concerns also regarding enabling NPs access to items for the treatment of hand and foot injuries, penetrating injuries and injuries to critical structures (eg. eyelid, lip, nose, genitals) without medical review. In addition, the request for access to an item equivalent to 30023 is not appropriate as it is a complex procedure which is done by specialist surgeons in the majority of cases.

Telehealth items

The AMA has long advocated for GP telehealth consultations, and if introduced, would support telehealth items for NPs only where they are working as part of an integrated health care team within the confines of a general practice medical home or a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

It is the AMAs view that technology-based patient consultations are an appropriate alternative to consulting with a patient in the same physical room when they are used:

- As an adjunct to normal medical practice
- For regular patients of the practice
- For patients who have been referred by another medical practitioner
- When it is clinically appropriate for the patient's circumstances

Any introduction of specific telehealth items should be aligned with the AMA position statement on Technology-based patient consultations – 2013.

The AMA has no objection to AHPRA registered allied health professionals privately practicing and who are a member of the patient's health care team being granted access to a rebate for participation in multi-disciplinary case conferencing.

Increasing rebates to NP attendance items

NPs are not medical practitioners, and do not have the comprehensive clinical training. The AMA would not support any increase to the schedule fee for NP items that would see NP services being rebated at an equivalent or higher level than that for non-vocational medical practitioners.

Appendix D – Response to questions raised by GPPCCC

Care facilitation item

A care facilitation service would be best funded as part of a blended payment rather than as an MBS rebated service item. As the NPRG recognised in their response to the GPPCCC care facilitation is more extensive than a single session and may require multiple touchpoints to be effective. The coordination of care must be supported, but in the AMA's view, coordination of care should be undertaken from the patient's medical home. A blended payment to practices or Aboriginal Health Services, aimed at supporting the coordination of

patient care would be more appropriate. The role of coordinating patient care could then be assigned to an appropriate member of the integrated multidisciplinary health care team, which may include, for example, a practice nurse or NP, an Aboriginal health worker or practitioner, or a pharmacist, whomever is more appropriate for the patient's care needs at the time.

Should you require any further information or clarification on the AMA's response to the Recommendations, please contact Michelle Grybaitis at mgrybaitis@ama.com.au.

Yours sincerely

Dr Tony Bartone
President