



RACGP

Royal Australian College of General Practitioners

*RACGP Submission:*

*Report from the Medicare Benefits Schedule  
Review's Nurse Practitioner Reference Group*

May 2019

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## 1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for the opportunity to comment on the report from the Nurse Practitioner Reference Group (the Reference Group).

The RACGP is Australia's largest general practice organisation, representing over 40,000 members working in or toward a career in general practice.

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist general practitioners (GPs) in their pursuit of excellence in patient and community service.

## 2. Recommendations

In relation to all reports and recommendations from the various Reference Groups reporting to the Taskforce, the RACGP recommends that the Taskforce:

- support recommendations that encourage continuity of care between patients and their regular GP and support team-based care in general practice
- reject recommendations that support health professionals to expand service provision without a genuine link to the patient's general practice – this will result in fragmentation of patient records and duplication of services, risking quality care and wasting valuable health resources
- support initiatives which strengthen rural general practice and increase the number of doctors working in rural and remote Australia and other areas of workforce shortage.

In relation to the Nurse Practitioner Reference Group report, the RACGP recommends that the Taskforce:

- reject proposals which expand the scope of practice for nurse practitioners to provide Medicare funded services, which seek to duplicate services and fragment care
- reject proposals to remove current requirements for nurse practitioners to collaborate with doctors in delivering care to patients, which will similarly fragment care
- advise the government to monitor and regulate the collaborative care agreements which have been mandated by legislation since 2010
- advise the government to better support the provision of GP-led primary care through implementing the [RACGP Vision for general practice and a sustainable healthcare system](#). This would include increased funding for general practices to employ a team of qualified health professionals, such as nurse practitioners, through the [Workforce Incentive Program](#)
- support the proposal to improve patient access to telehealth services by expanding the scope of providers eligible to participate in consultations to include GPs
- reject proposals to create new, and expand current, nurse practitioner telehealth items.

### *3. RACGP Position*

The RACGP:

- supports and encourages the role of nurse practitioners within GP-led general practice teams, either co-located or external to the general practice location
- sees nurse practitioner and general practitioner roles as complementary, but not interchangeable
- does not support nurse practitioners working autonomously in the primary healthcare sector.

RACGP members have expressed a number of concerns about the proposals put forward by the Reference Group. These are outlined below.

### *4. Rationale*

#### **4.1 Health workforce issues**

##### **4.1.1 Patient access in underserved areas**

The Reference Group proposes expanding the scope of practice for nurse practitioners (Reference Group recommendations 1-3, 6, 7, 9, 10). The Reference Group states that this will increase patient access to primary healthcare services, and increase patient choice regarding which practitioner to seek primary healthcare services from.

The RACGP agrees that medical workforce mal-distribution issues that particularly affect patients located in rural, remote or Aboriginal and Torres Strait Islander communities, must be addressed. However, expanding the scope of practice for nurse practitioners is not a long-term solution to workforce issues. Patients in underserved communities have the right to the same standard of medical care as patients in metropolitan and regional areas.

The Reference Group claims their proposal will increase patient choice of health practitioners. In reality, it risks creating a two-tiered system, where patients who cannot access GP services (for example due to cost or geographic location) will instead see the nurse practitioner as their first point of contact. This is likely to reduce equality of care and increase health disparities for already disadvantaged communities.

Convenient healthcare does not necessarily equal quality healthcare. While allowing nurse practitioners to practise autonomously may increase patient access in some areas, the role of General Practitioners and Nurse Practitioners are not interchangeable, and access to services alone does not benefit patients. Patients need access to *safe, comprehensive, coordinated* and *high-quality* health services provided by the most appropriate and qualified health professional.

All Australians deserve the same level of care. If a two-tier model of primary care is created, comprehensive expert care would be available in some areas and for some people, while a lower level of autonomous care would be available in other areas.

##### **4.1.2 Nurse practitioners are not interchangeable with medical practitioners**

GP training involves a competitive entry process, six years of intensive training in medical school, postgraduate training of four to five years, and Fellowship examinations, followed by ongoing continuing professional development throughout the career. As a result of this intensive educative process, GPs are appropriately trained to manage undifferentiated presentations, emergencies, complex pharmacology decisions, multi-morbidity, and thousands of rare and common medical conditions. GPs are able to work efficiently, dealing with multiple matters within a single consultation.

In comparison, and as stated by the Reference Group in their report, the training to become a nurse practitioner requires a three year bachelor of nursing, four years of clinical experience, followed by a one- or two-year Master of Nursing or equivalent.

Nurse Practitioners do not have the breadth of training required to assess a broad range of undifferentiated health problems, and should not be expected to provide the same level of care as a medical practitioner. Expanding the scope of practice for nurse practitioners, as per the Reference Group's report, may result in unusual (and sometimes serious) conditions not being recognised and managed appropriately, due to a lack of adequate training and expertise.<sup>1</sup>

In addition, autonomous primary care led by nurse practitioners would lead to greater dependence on investigations and referrals, and thus reduced system efficiency – undermining the original intent of the recommendations.<sup>2</sup>

**In relation to all recommendations put forward to the Taskforce from reference groups, the RACGP recommends that the Taskforce:**

- **support recommendations that encourage continuity of care between patients and their regular GP, as opposed to supporting the expanded role of other health providers**
- **support initiatives which strengthen rural general practice and increase the number of doctors working in rural and remote Australia as the primary way to address workforce shortage.**

## **4.2 The importance of coordinated and continuous care**

### **4.2.1 Evidence supporting GP-led team care**

The Reference Group states that recommendations 1, 2, 8, 9 and 10 are aimed to address system inefficiencies and remove barriers to care. The RACGP does not believe there is evidence to support these claims.

Evidence supporting the effectiveness of primary care, with GPs at the centre of care, is well established.<sup>3</sup> Continuity of care through long-term ongoing relationships between patients and GPs is associated with lower preventable hospital admissions and lower risk of mortality.<sup>4</sup> International and Australian experience has repeatedly demonstrated that GP-led multidisciplinary healthcare teams achieve the best health outcomes for patients.<sup>5,6</sup>

There is a lack of corresponding evidence to support successful primary care models without generalist clinician leadership. There is no clear evidence that nurse-doctor substitution saves money or reduces the workload of GPs. Efficiency gains are not observable due to a high level of task duplication and patient confusion around role delineation.<sup>7</sup>

Independent nurse practitioners seeking to provide care to patients in isolation from general practice will:

- increase the health system's complexity and access points
- duplicate patient services (eg consultations, pathology and diagnostic imaging) due to care not being coordinated through a central point of care – the patient's general practice
- result in inappropriate and unnecessary referrals to other healthcare professionals / services<sup>8</sup>
- increase waiting times for referred services due to an increase in unnecessary referrals<sup>2</sup>
- reduce the efficiency of resource allocation and increase costs, and increase flow-on costs throughout the healthcare system.<sup>9</sup>

The Reference Group's recommendation number 8, to allow nurse practitioners to work without medical oversight in the form of formal collaborative care agreements, must not be supported. Further, the RACGP recommends that the MBS Review Taskforce make recommendations to the government that strengthen the collaborative care agreements which have been mandated by legislation since 2010. This should include the development of mechanisms to appropriately monitor and regulate the agreements. The RACGP provides guidance on how collaborative care agreements should be developed, and what should be documented, in its position statement on [Nurse practitioners in primary healthcare](#) and Guide for [Collaborative care agreements in general practice](#).

Nurse practitioners have a valuable role in primary care as part of a GP-led team. The RACGP acknowledges their well-developed skills in key areas such as wound care, immunisation, and working with

nursing home clients. As stated previously, the RACGP [Vision for general practice](#) is a framework for excellence in healthcare that is centred on the importance of GP-led team based care. A well-resourced, multidisciplinary GP led-team has the capacity to coordinate care and ensure that patient needs are met.

#### 4.2.2 The proposed reforms risk fragmentation of care

The RACGP welcomes and encourages other healthcare providers' contribution to providing comprehensive and coordinated patient care. However, the RACGP does not support multiple health professionals offering the same services, as this increases the risk of duplicated services, fragmented care, and wasted valuable health resources.

GPs remaining as the patients' first point of contact within the healthcare system and retaining ultimate oversight of patient care allows for comprehensive assessment, diagnosis, initiation of treatment, and referral to appropriately qualified team members (including nurse practitioners) in accordance with their qualifications, areas of clinical expertise and levels of support.<sup>10,11</sup>

Nurse practitioners intervening in the treatment of general practice patients independent of the GP-led team may compromise continuity of care through:

- fragmented medical records
- the provision of contradictory clinical advice
- missed opportunities to detect contra-indications
- missed opportunities to initiate a range of opportunistic health promotion and disease prevention activities
- diminished clinical governance and accountability.

A patient's regular GP can provide informed, tailored advice to patients by drawing on:

- long-term care relationships
- the patient's medical history held by the practice
- records of the patient's conditions, treatments and medications.

Losing this important opportunity for holistic, comprehensive and integrated care could prove detrimental to patients.<sup>12,13</sup>

#### The RACGP recommends that the Taskforce:

- **reject proposals which expand the scope of practice for nurse practitioners to provide Medicare funded services**
- **reject proposals to remove current requirements for nurse practitioners to collaborate with doctors in delivering care to patients**
- **advise the government to monitor and regulate the collaborative care agreements which have been mandated by legislation since 2010**
- **advise the government to better support the provision of GP-led primary care through implementing the [RACGP's Vision for general practice and a sustainable healthcare system](#). This would include increased funding for general practices to employ a team of qualified health professionals, such as nurse practitioners through the Workforce Incentive Program.**

### 4.3. Telehealth

The RACGP supports including GPs as eligible participants in nurse practitioner patient-side telehealth services, and ensuring all Aboriginal and Torres Strait Islander peoples are eligible to access telehealth services, not just those who are patients of Aboriginal Medical Services or Aboriginal Community Controlled Health Services. This would increase patient access to general practice services, particularly in remote areas, and increase coordination of care between nurse practitioners and GPs.

However, the RACGP does not support the creation of new MBS items for direct nurse practitioner-to-patient telehealth consultations. Direct nurse practitioner-to-patient telehealth consultations are not

appropriate as care should continue to be coordinated through the patient's GP. While the RACGP supports the modernisation of consultative medicine via greater access to non face-to-face services, the first step must be to remove rules in the MBS that state GP-patient consultations must be provided face to face.

The RACGP sees that, subsequent to improvements in Medicare funding for GP-patient telehealth consultations, there would be opportunity for nurse practitioners working as part of a GP-led team to provide care via telehealth.

The RACGP's position on telehealth is outlined further in the position statement on [on-demand telehealth services](#) and our [2019 Election Statement](#).

**The RACGP recommends that the Taskforce:**

- **support the proposal to improve patient access to telehealth services by expanding the scope of providers eligible to participate in consultations to include GPs**
- **reject proposals to create new, and expand current, nurse practitioner telehealth items.**

## *5. Conclusion*

### **5.1 Reinvestment of savings from the MBS Review**

The federal government has committed to reinvesting MBS Review savings back into Medicare. The RACGP calls on the Taskforce to provide more transparency regarding this reinvestment by detailing the savings that will be made, and the additional spending that will be required, to any recommendations it makes to the government. The RACGP would also like to see, in detail, how the MBS Review savings have been, or will be, reinvested into the health system, particularly into general practice.

While making improvements to the MBS are essential, this alone will not be enough to ensure a sustainable health system in the long term.

The way in which the government supports patients to access general practice services requires a comprehensive redesign. GPs and practices receive minimal or no support for providing essential aspects of patient care, such as:

- continuity of care – formalising relationships between patients and their GP
- health service coordination – improving coordination between various levels of the health and social systems
- comprehensiveness of care – supporting patients to access the range of services they require
- team-based care – ensuring patients are benefiting from access to a multidisciplinary healthcare team.

### **5.2 Ongoing support for the MBS Review**

The RACGP notes the recent decision for the MBS Review to conclude by mid-2019, despite commitment in the 2017-18 Federal Budget to fund the review until at least 2020. The RACGP recommends that any changes made as a result of the MBS Review be subject to rigorous monitoring, evaluation, and consultation with stakeholders, to ensure that the intended results are being achieved.

The RACGP looks forward to hearing the final recommendations and outcomes from this Report, and further participation in future MBS Review consultations, including an evaluation of any changes made as a result of the MBS Review.

If you have any questions or comments regarding this submission, please contact Ms Susan Wall, Program Manager – Funding and Health System Reform, on (03) 8699 0574 or at [susan.wall@racgp.org.au](mailto:susan.wall@racgp.org.au)

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