Australian College of Nurse Practitioners

Pre-Budget Submission 2022-2023

Supporting access to the Nurse Practitioner Workforce

The following organisations support, and have contributed to the development of this pre-budget submission

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TABLE OF CONTENTS

Foreword 2

Proposal Overviews 3
- Proposal 1 - Increasing the rebates
- Proposal 2 - Closing the Gap

Proposal 1 – Supporting Information 4
- Table 1
- Table 2
- Table 3

Proposal 2 – Supporting Information 7

Conclusion 8

References 9

Appendices 10
- Appendix 1
- Appendix 2

FOREWORD

This group of peak nursing organisations request consideration of this pre-budget submission for the upcoming Federal budget, with the aim for implementation on 1st July 2022.

There are significant existing barriers to Nurse Practitioner (NP) roles in Australia, particularly in relation to Primary Care, Mental Health, Rural and Remote areas, Aboriginal and Torres Strait Islander Health and Aged Care. While the important work of the Nurse Practitioner 10 Year Plan Steering Committee is well underway, and is vitally important, this pre-budget submission would greatly support this work, and ensure the workforce is available when outcomes of the 10-Year plan are ready for implementation.

We know that many Australians, especially those at a disadvantage, can struggle to access health care at the right time, and this is further exacerbated in remote and rural areas. The two key proposals within this pre-budget submission aim to ensure that:

- Access to health care is improved, especially for disadvantaged people
- People are not disadvantaged because the only health provider they can access is a NP
- NPs are able to sustainably remain in roles in the private sector, and work in primary care settings sustainably such as GP practices and ACCHOs
- Disincentives to employing or engaging NPs are reduced
- Advanced practice nurses can have more confidence in enrolling in courses that lead to endorsement as a NP, leading to workforce development and increasing numbers of Nurse Practitioners
- Aboriginal and Torres Strait Islander people are not disadvantaged if they choose to see a NP, and/or only have access to a NP

Further, this proposal would also significantly improve goodwill and confidence in relation to the Nurse Practitioner 10 Year Plan (NP 10 Year Plan) within the current NP workforce, and the wider nursing workforce.

The key objective of this proposal is to support the most immediate and critical needs of the NP workforce, and their patients, prior to implementation of any outcomes from the work of the NP 10 Year Plan Steering Committee.

PROPOSAL OVERVIEWS

Summary of Proposal 1 – Increasing the rebates:

Action:	To increase Nurse Practitioner time-based rebates (Table 1)
Timeline:	1st July 2022
Projected cost:	$18million in 2022/2023, or $133 million over 5 years (20% annual increase in services) (Table 1)
Cost Savings:	Earlier intervention and preventative care is well documented as highly cost effective, especially when accessible, affordable, and delivered closer to home. This particularly applies in Primary Care, Aged Care, Mental Health, Rural and Remote areas, and in Aboriginal and Torres Strait Islander Health[1, 2, 3]. Enabling NPs to work sustainably in these areas can prevent some of the high costs associated with chronic disease, placement of locum practitioners, and avoidable hospital admissions [1, 4, 5, 6, 7], making this a low cost/high return proposal in terms of health care dollars, and human cost.
Benefits:	Cost savings to patients and consumers are also significant, reducing delays to care, the burden of travel and out of pocket costs. Furthermore, advanced practice nurses in Australia, would be more likely to enrol in courses leading to endorsement as a NP, and move into NP roles in Primary Care, Aged Care, Rural and Remote areas, and in Aboriginal and Torres Strait Islander Health.

Summary of Proposal 2 – Closing the Gap:

Action:	Existing Close the Gap initiatives be extended fully to patients of Nurse Practitioners
Timeline:	1st July 2022
Projected cost:	Administrative costs to implement the change
Cost Savings:	Reduction of duplicated consultations as some patients eligible for PBS Prescriptions under CTG currently need to seek secondary consultation in order to access their entitlements. This will also add incentive to employ or engage NPs, with savings in relation to the cost of locum services and workforce turnover, especially in rural and remote areas, and ACCHOs.
Benefits:	Improved access to care and timely access to medicines for people eligible for CTG, and a reduction in complications and costs associated with poor chronic disease management[8]. Consistent access to CTG regardless of the type of PBS prescriber will also reduce confusion.

PROPOSAL 1 – Supporting Information

Increasing the rebates:

Currently, MBS rebates for patients of NPs sit just below 50% of the rebates that patients receive for allied health services, and even lower comparatively with medical practitioners. This directly impacts on patient access to healthcare services, especially in relation to marginalised populations, and in rural, regional, and remote areas. It is also well-established that this negatively affects the ability of NPs to work in these regions, for them to work in private practice, or be employed in the primary care sector, especially where patients/consumers are unable to afford out-of-pocket costs. We have compared NP rates directly with allied health rates, in the absence of any other reasonable measure available.

We have recently seen the announcement of additional support for medical practitioners and nurse practitioners through the reduction in university debt for those who choose to work in rural, regional, and remote areas. Unfortunately, without addressing the rebates for NP services, there is unlikely to be any increase in NP numbers in these underserviced areas, as the business models will continue to be unsustainable, both as private practitioners, or employees in private practice. We would like to see an uptake of this proposal as soon as possible, especially in the interests of rural and remote health.

While the work Nurse Practitioner 10 Year Plan Steering Committee will address many of the workforce issues, it is imperative that the rebate increase is implemented sooner rather than later, as there are currently well documented negative and ongoing impacts on the NP workforce. This change will ensure the workforce is less likely to deplete and will improve interest and commitment to enrolling in NP training, as nurses see there is now a viable option in private practice and primary care. The time for a nurse to enrol and complete training and meet the requirements for endorsement can be anything between 2 and 5 years.

Increasing the rebate now will also increase the confidence of the nurse practitioner workforce, and the wider nursing workforce, in relation to Government support for the NP role, and support the work of the Nurse Practitioner 10 Year Plan Steering Committee. This would represent a significant commitment of goodwill and commitment to nursing and health.

Supporting Data:

Supporting data were prepared based on MBS items (and rates) from July 2017-June 2020, and would require an additional $18 million per year, with a projected increase of 20% per year as NP services become more viable, and numbers increase. This can be seen reflected in Table 1.

Current MBS time-based consultations with NPs proportionally is only 0.5% when measured over a three-year period against Vocationally Registered (VR) GP and Non VR MBS items (Table 2).

Table 1

Item	Current (30th June 2020)	Proposed rebate	Proposed rebate applying July 1 2020 indexation
82200	8.20	16.63	**17.46**
82205	17.85	35.28	**37.05**
82210	33.80	52.95	**55.60**
82215	49.80	103.32	**108.49**

Item	Services for period	Old rebate	Proposed rebate	With July 1st 2020 indexation
82200	40428	331510	672318	705934
82205	228787	4083848	8071605	8475185
82210	224471	7587120	11885739	12480026
82215	135288	6737342	13977956	14676854
Total		18739820	34607618	36337999
Difference /budget increase			**$15,867,798 (30/06/20 data)**	**$16,661,188 (01/07/21)**

Increasing rebates, as per the costings submitted, reflects an overall increase to MBS cost of 84% in the sample period., However this corrects the disparity in rebates for consumers in a fair and reasonable way. This also recognises and supports the level of training, and the advanced care offered by our most experienced and autonomous members of the nursing workforce.

Based on projected Budget for 2022-2023, the budget would need to include an additional $18 million to account for the steady increase in NPs in Primary Care since the 2019/2020 data, and the indexation of MBS rebates each year on 1st July.

Projected growth of NP numbers would increase from the current annual 9% increase, as other primary care providers (including GP clinics and ACCHOs) begin to employ more NPs, and more NPs are able to establish their own practices. We project this growth could be as high as 15% - 20% per year.

Table 2

Items	Total Services 01/07/2017-30/06/2020	Proportion as % of time based services
Nurse Practitioner 82200,82205,82210,82215	1,665,308	**0.5%**
Non VR Doctor 52, 53, 54, 57	12,909,187	3.5%
VR GP 3,23,36,44	353,159,750	96%
Total time based consultations (GP+NP)	367,734,245	100%

Over 3 years – July 2017-June 2020, NP time-based services have represented a total proportion (NP:GP) of time-based attendances of 0.5% of primary care attendances. Data were collected using VR and Non VR GP time based items, and NP time based items.

Table 3

Items	Cost to MBS with increase Based on sample period	Proportion as %
NP 82200,82205,82210,82215	$51,930,561	**0.3%**
Non VR 52, 53, 54, 57	$329,754,037	2.1%
VR GP 3,23,36,44	$15,515,878,872	97.6%
Total time based consultations	$15,897,563,470	100%

Proportional cost of NP services for the year 1/7/19-30/6/2020 (last data collection period available) period at new suggested rates (adjusted to Allied Health equivalent). This remains well below the 0.5% proportional rate of time-based consultations, even with the proposed rebate increase, reflecting excellent value for money.

This proposal reflects a cornerstone opportunity to improve the delivery of health care in Australia, particularly to marginalised and vulnerable people. While our key focus is on this proposal, we also attach for your interest (Appendix 1 and 2), other potential cost savings that can significantly improve health outcomes, although we are also committed to addressing these through the work of the Nurse Practitioner 10 Year Plan Steering Committee.

Proposal 2 – Closing the Gap

The CTG PBS Co-payment

The PBS Co-payment measure refers to PBS prescribers, which would appear to include NPs as prescribers, however there are existing limitations in relation to PBS access for patients of NPs.

This proposal is to expand access to medicines under the CTG PBS Co-payment measure that can be prescribed by a Nurse Practitioner, within their authority and expertise, to the full list of PBS medicines that can be prescribed by a Medical Practitioner on the General Schedule. This is not intended to expand the range of medicines able to be prescribed by a NP, but to provide equity of access to medicines for patients eligible for CTG.

Currently there are inequities for patients eligible for CTG prescriptions (and all patients) who choose to see, or may only have access to, a NP. As PBS is limited for Nurse Practitioners as prescribers, and some PBS medicines are only able to be prescribed by NPs as 'continuing only' medicines, these limitations directly affect patients, no more so than those already at a disadvantage, or living in remote areas.

This proposal would not incur any additional cost as the CTG program is funded per capita, however would improve access to, adherence to, and affordability of prescribed medicines for chronic disease.

Examples of medicines on the PBS for patients of Medical Practitioners, unable to be prescribed by NPs on the PBS:

- Timolol 0.5% eye drops and Latanoprost eye drops 0.005% (individually or in combination) – used for the management of glaucoma
- Pimecrolimus 1% cream – used for dermatological conditions, including chronic eczema
- Zoledronic Acid 5mg/100ml injection - for the treatment of osteoporosis
- Mometasone Ointment 0.1% - used for the treatment of acute and chronic skin conditions, including chronic eczema – can only be prescribed on PBS as continuing therapy only, and cannot be initiated by a NP.
- Ezetimibe 10mg tablet – used for the treatment of elevated cholesterol - can only be prescribed on PBS as continuing therapy only, and cannot be initiated by a NP

*a more comprehensive list can be supplied

Medicines that are not on the PBS for patients of NPs must be written as a private prescriptions, resulting in the patient paying full price, and also not contributing to their safety net.

We propose that patients eligible for the CTG PBS Co-payment should have access to all medicines on the General Schedule whether prescribed by a Medical Practitioner or NP.

In the longer term, we propose these PBS inequities be addressed for the benefit of all health care consumers.

We look forward to hearing your response to our proposals and pre-budget submission. In the meantime, please do not hesitate to contact Leanne Boase at the Australian College of Nurse Practitioners for any clarification or further data or information required.

Leanne Boase
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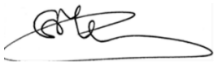

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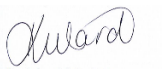

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Appendices

The following are just two examples of the potential for improvement in health outcomes by allowing NPs to improve referral pathways, and intervene earlier to reduce the risk of poor health outcomes. These examples highlight improved access to care, especially for marginalised and disadvantaged people, and also offer cost savings at the same time. Another major area for improvement is in Aged Care, there is enormous potential for preventative care, improvement of health care, better access to care, and chronic disease management, as well as palliative care. While it is difficult to quantify, cost savings would be seen through early intervention and a reduction in avoidable hospital admission. Further work is planned to investigate potential cost savings and benefits.

Appendix 1:

Item 715 – ATSI Health Assessment item
MBS Rebate $220.85

Nurse Practitioners (NPs) are currently not able to perform these assessments under MBS. Currently the NP advises the patient to see a GP, where the practice nurse usually performs the assessment. This needs to refer to a GP duplicates the initial consultation cost. This also delays the assessment, and as the patient has to book and attend an additional appointment, may well reduce the likelihood of the assessment being completed. In many cases, significant travel may also be required to attend a second consultation.

NPs could provide this service directly, reducing the resources needed and delays involved, and reduce the duplication of the initial consultation fees. Additionally, longer term savings via an improvement in uptake of this assessment are achievable through preventative health strategies.

It is widely accepted that many people in rural and remote communities may have access to NPs where no other health services are available, and there is strong evidence that NPs are more likely to work with ATSI people.

In 2019-2020, just under 225,000 of these Health Assessments were conducted. Without the need for referral to a GP, and with the NP performing this assessment at the initial consultation in approximately 20% of cases, the potential saving from this time period would be $1,162,125 (based on initial consults 82205 or 82210 at 2019/2020 rates) through reduced duplication of initial consultation items.

This example relates to only one Health Assessment item. However, it is a good example of how avoidance of unnecessary duplication of services, in relation to diagnostic items, health assessment items and care plan items can reduce the health dollar spend overall. Nurse practitioners would need access to enable referrals to Allied Health under Chronic Disease Management Plans for this measure to be effective.

Appendix 2:

Another example is in relation to duplication of initial consultations for Mental Health Treatment Plans (MHTP).

It is widely accepted that patients are comfortable disclosing mental health issues and trauma with nurses, and NPs conduct long, patient-centred consultations to establish the rapport often necessary for this to occur (See Table 1). Therefore, we assert that the rates of NP referral to GP for MHTP preparation could actually be much higher than what we are suggesting here.

Currently, NPs cannot refer patients to Psychologists, Mental Health Nurses, or Mental Health Accredited Social Workers, and the patient must go to a GP to repeat the consultation, repeat their disclosure of mental health issues, and potentially increase their trauma by doing so, in order to be eligible for a MBS rebate. The need to repeat their concerns potentially also delays and reduces the chance of follow up and early intervention, further adding to health system costs in the longer term.

In 2019-2020, the number of initial MHTPs (Item 2700+2701+2715+2717) totalled 1,271,833. If 10% of these were conducted by NPs, instead of the NP having to refer to the GP, this would reflect an annual cost saving of $3.3 million (based on initial consults 82205 or 82210 at 2019/2020 rates).

The budget increase required to enable NPs to prepare MHTPs for 2022-2023 is estimated to be $17 million, with an annual projected increase of 20%. Savings to the Health Budget are predominantly related to reducing waiting times, and an improvement in preventative health care. Further potential savings have been demonstrated through the addition of other MBS items for patients of NPs, predominantly through reduction in duplicated services, improved access to timely care, and reduction in delays to care. NPs would need access to enable referrals to Allied Health under Mental Health Treatment Plans for this measure to be effective.