New general practice nursing funding announcement – implications for general practice nurses

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Overview

1) *What is it?*

Commencing in January 2012, it an investment of almost $400m over 4 years to nursing services in general practice. It is $25,000 per GP (in an accredited practice) incentive towards employment of a registered nurse and $12500 towards employment of an enrolled nurse up to 5 incentives. Current PIP practice nurse subsidy and PN 'for and on behalf' of item numbers to be redirected to this new incentive. Nurse contribution to GP item numbers such as health assessments and GPMPs to not be changed.

2) *Positives for practice nurses.*
   - *i)* Replacement of the ambiguous 'for and on behalf of' concept with block incentives to reduce confusion over legal accountability and ensure correct allocation of funding
   - *ii)* Increased scope of duties for practice nurses, allowing for greater flexibility in operation of practices
   - *iii)* Recognition of nurses' varying qualification levels
   - *iv)* Increased opportunity for development of skills and new nursing services, as proven overseas in the results of similar funding schemes

3) *Areas we will advocate for clarity and/or improvement*
   - *i)* Recognition of and incentives for advanced nursing roles
   - *ii)* Disincentives for practices to allocate inappropriate administrative tasks to nurses' duties
   - *iii)* Continued recognition of nursing contribution
   - *iv)* Assessment of the impact of the new funding scheme on practices with high nurse-GP ratios to ensure continued security for nurses' jobs and for practices that efficiently meet patents' needs
   - *v)* Funding for infrastructure to allow for increased nurse employment
   - *vi)* Further incentives for high quality care

4) *Areas of concern regarding GPs*
   - *i)* Employed or contractor GPs may experience resentment at 'loss of income' resulting from the new scheme
   - *ii)* A lack of clear definition of the job description and role of the nurse

5) *Other concerns*

   Such a significant change naturally presents anxiety for many of us. You may be concerned about the change of focus in your job role. You may be concerned about your job role if your practice considers the new scheme to be detrimental. At this stage it is most important to remain calm as we wait for more details and work with the government and other stakeholders towards implementation in 2012. You may wish to liaise with your practice in team meetings to learn more about the implications of the new funding scheme.

Introduction and Announcements

The Commonwealth Government has announced a revamp to the way in which nursing in general practice is funded. This initiative will support an expanded and enhanced role for practice nurses with a new, simplified and streamlined financing arrangement.

Current funding for practice nurses through the Practice Incentive Program practice nurse incentive and the Medicare Benefits Schedule practice nurse items will be redirected to this simplified, single funding stream to be administered by Medicare Australia from 1 January 2012.

General practices across Australia, accredited under the general practice standards of the Royal Australian College of General Practitioners, including those in urban areas, as well as Aboriginal Medical Services, will be eligible for an incentive to offset the costs of employing a practice nurse. The incentives will be $25,000 per full time GP for a Registered Nurse and $12,500 per full time GP for an Enrolled Nurse in recognition of the different skills of Registered Nurses and Enrolled Nurses.

The program will be capped at five incentives, meaning that practices will be eligible to receive up to $125,000 to support their practice nursing workforce. The new arrangements will also include:

- support for all accredited practices to employ an Aboriginal Health Worker instead of or in addition to a practice nurse (Registered Nurse or Enrolled Nurse).
- support for practices in urban areas where there are workforce shortages and Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ an allied health professional such as physiotherapists, dieticians and occupational therapists, instead of, or in addition to a practice nurse and/or Aboriginal Health Worker.
- a rural loading based on Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).

RA 1 Major City	0 %
RA 2 Inner Regional	20 %
RA 3 Outer Regional	30%
RA 4 Remote	40 %
RA 5 Very Remote	50%

- a one-off $5,000 incentive to support eligible non-accredited practices to become accredited.
- grandfathering arrangements for the first three years of the program to ensure that practices are not adversely impacted by the restructure of the Practice Incentive Program practice nurse incentive and the MBS practice nurse items.

Practice nurses can play a key role in pro-actively supporting patients in the optimal management of their health conditions. The new arrangements will

support practice nurses to undertake a broad range of activities which are not well-supported under the current financing arrangements including:

- providing preventative health programs and education programs
- quality chronic disease management and care coordination
- supported self management
- providing recall and reminder systems

Additionally there was funding for general practice infrastructure announced with over practices being able to apply for over 400 grants up to $500,000 towards rooms etc for nurses and allied health.

Current Funding structure

As most of you know nursing in general practice has been funded by the following mechanisms:

- A practice incentive payment subsidy for practices in rural and remote areas and areas of low socioeconomic disadvantage and workforce shortage. The subsidy pays the practice $8000 per full-time equivalent GP up to 5 GPs i.e. a maximum of $40,000.
- A range of MBS item rebates for practice nursing activities – immunisation, wound management, pap smears, pap smear and preventive health check, antenatal care, chronic disease management and 4 Year Old Healthy Kids Check. These item numbers are 'for and on behalf of' the GP and pay between $11.35 for most, $22.70 for the pap smear and preventive health check, $25.80 for the antenatal item number up to $55.00 for the Healthy Kids Check.
- Contributions to item numbers that must be completed by GPs, such as the Health Assessments, GP Management plans and Team Care Arrangements, and SIP item numbers such as the Diabetes Annual Cycle of Care.
- Nurses can contribute to the achievement of PIP outcomes such as the cervical screening and diabetes Service Outcome Payments.
- GPs being able to increase their throughput and therefore income by having a practice nurse to give care & perform many tasks on their behalf

Current Funding Issues

APNA has been raising concerns about the current funding mechanisms for nurses in general practice for a number of years. We have argued that current funding has the following problems:

- The overall amount paid for MBS items and the nurse PIP subsidy is insufficient to provide a reasonable nurse to GP ratio.
- Remuneration does not differ in accordance with the skills and qualifications of the nurses, which creates a perverse incentive for practice owners to employ the least expensive nurse or pay the minimum amount legally possible. A consequence of this many practices have a problem with recruiting quality staff or retaining them.

- It is unduly complicated, requiring practices and nurses to implement complex business arrangements to make full use of the available funding
- The MBS item funding is largely restricted to a series of tasks which means that nursing roles are shaped by these funded tasks, rather than being shaped by the practice and the nurse to meet the needs of local populations. A further consequence of this is the inability of the item numbers to fund comprehensive care – in reality many nursing consults, like GP consults, involve a range of clinical and psychosocial issues which need to be funded. In order to expand the current funding available for other activities, the normal government solution is more item numbers. An item number for prevention, breastfeeding advice, cardiac rehabilitation, continence management and sexual health screening are among the many that we have seen as proposals or suggestions over the years. A system of multiple MBS item rebates for multiple tasks is increasingly complex for practices to manage.
- As with GP attendance item numbers, the most financial benefit for the practice comes via high throughput, rather than quality of care. This effect is exaggerated for nursing as the rebates are not increased with time spent.
- Contribution to the GP Health Assessments etc is among the more lucrative ways practices can access funding for nurses. However, the activities listed as appropriate nursing roles on the Medicare Schedule (i.e. information gathering and providing patients with information about recommended interventions at the direction of the GP) do not reflect the highly skilled clinical expertise that nurses can deliver. This expertise includes assessing the health of patients, making clinical recommendations to the GP and undertaking high quality patient education as necessary.
- The PIP subsidy is not available everywhere and its financial benefit is linked to the number of GPs in the practice. It can be argued that a reduction in numbers of GPs in a practice results in an increased need for nursing services, not a decreased need. Nursing services are not dependent on the availability of ‘supervising’ GPs and have been shown in areas of workforce shortage to greatly enhance the access of patients to GPs. If a practice loses a GP, the PIP incentive should not compound the problem by reducing the subsidy payment for nursing services.

General practice funding at a glance

General practice funding in any setting can comprise one of many of the following elements:

- **Fee-for service payments** which provide rebates for a service provided e.g. current MBS item numbers. Positives and negatives for this payment method are:
  - Positive
    - It pays for easily identifiable services, such as time-based attendances

        - Provides incentives for health professionals to work longer hours
        - Can be less bureaucratically complex, if the system is simple
    - Negative
        - Encourages volume and can be an ‘open cheque book’
        - Has few levers to encourage quality
        - Does not provide incentives for a fair distribution of the workforce eg: to areas of workforce shortage
        - Tied to a particular health professional
- **Capitation** which pays the practice a block payment for the care provided to a particular population, or per person. The proposed Diabetes care package is an example currently of one payment for a range of care to be provided under it. Possibly a more well-known and cited example has been the UK NHS system of funding general practice. Positives and negatives for this payment method is
    - Positive
        - Encourages integrated care with a multidisciplinary team
        - Can tailor packages of services to patients based on need rather than on funding
        - Is less concerned about which professional does which task resulting generally in increased role for nurses
    - Negative
        - Can encourage ‘stinting’ or lazy practice of providing minimum care
        - Is problematic where risk-adjustment is needed for different patient loading on the practice e.g. practices with high numbers of complex patients.
        - May see increase in roles for other roles such as physician assistants or other non-clinically trained persons
- **Salary** is a method similar to some current community health centre models where funding is provided to organizations up front, who then are free to create salaried positions. Positives and negatives for this payment method is
    - Positive
        - Provides security of income and additional benefits in some organisations such as salary packaging
    - Negatives
        - Is associated with lower productivity than fee-for-service
- **Grants** are the provision of a set amount of money to achieve a set outcome, generally a process outcome. Positives and negatives for this payment method are
    - Positive
        - Provides flexibility
        - Provides predictability of spend for government
    - Negative
        - Is time-limited, which can lead to cessation of service in the long run and thus low predictability of income
- **Pay for performance** is payment on achievement of certain outcomes and a current example is the PIP outcomes payments which are paid on achieving 90% immunisation rates or 20% of patients on a diabetes cycle of care. Positives and negatives for this payment method is

- Positive
  - If good indicators, has been shown to result in changed clinician behaviour and adherence to clinical guidelines
  - Is less concerned about which professional does which task if outcome the same which results in increased roles for nurses.
- Negative
  - Can be challenging to findthe right indicators to provide the right incentive
- Can provide a perverse incentive for health organizations to work with patients who are likely to meet targets, in preference to working with patients who have complex care needs eg: many disadvantaged and elderly people

Evidence shows[i] that the most effective health systems use blended payment methods to capture the positives and minimise the negatives of each model. Australia currently has a blended payment system but with a strong emphasis on fee-for-service arrangements through Medicare.

Positives for general practice nurses of the new incentive

1. Removal of the 'for and on behalf of' concept, which in the past has created significant confusion over who is legally accountable for care provided by a nurse, who can determine what 'appropriately qualified' means for the nurses. Nursing regulation requires nurses as professionals to be accountable for the care they provide at all times and direction or supervision by a GP is no defense in a court of law. In addition, with the item numbers being submitted under the GP provider number, some practices have business arrangements stipulating GPs earn a percentage of all MBS income under their name. This results in 50-80% of income generated through the nurse going to the GP before practice and nurse salary costs are provided for. Block grants to the practice ensure that funding goes towards the provision of nursing services.
2. Flexibility within the general practice to use the particular skills of the nurse for the needs of their practice population. Where nurses bring skills such as continence management, sexual health screening, motivational interviewing etc they will be able to work to their full scope of practice. The lack of ability to do so at present is a constant source of frustration for nurses.
3. Recognition of the different qualifications of nurses, particularly between an enrolled nurse and registered nurse. An effective nursing team will comprise a range of differently qualified nurses working together. Currently enrolled nurses comprise around 11% of the practice nursing workforce. It is important to remember this is an incentive towards employment of nurses (at present not specifying numbers of hours) and in no way implies that pay rates for enrolled nurses be 50% of the registered nurse, rather that the preferred ratio favours higher numbers of RNs to ENs.

4. Block grant flexible funding in other countries has seen a range of opportunities open up for nurses to develop new nursing services as they see a need and are interested in developing those skills.

Areas APNA will be advocating for improvements or clarity in the current proposal

1. Need for recognition of more advanced nursing roles and financial incentives for practices to employ nurses with advanced skills or who have undertaken further professional development.
2. Need to ensure that the role for nurses is clinical and to provide disincentives for practices to require nurses to undertake primarily non-clinical roles such as administrative tasks. However this will be complex as there are some administrative tasks that are usefully undertaken by nurses, such as management of the nursing team, recall and reminder system management etc.
3. Need to ensure that the nursing contribution does not become invisible in this process. APNA will encourage the government to recognise and reward nursing performance in this domain
4. Need to assess what the impact will be on practices who currently operate at a high nurse to GP ratio. While we may need to await further announcements to fully understand the financial impact of the changes, we need to make sure that practices who have been very good at getting the most out of the current system for patients are not worse off. While the government has indicated this an overall increase in funding going towards nursing through this initiative, we don't want to see any nurses losing positions as a result of this.
5. Whilst recognizing that the proposed diabetes incentive package has an incentive to drive practices to place an emphasis on chronic disease management, we need to be reassured that there will be some further measures in place to provide incentives for high quality care
6. One of the issues we will be raising strongly is that there needs to be requirements *on top of* accreditation status in place for receiving the payment such as access for nurses to professional development, access to the medical records when providing clinical care, having appropriate job descriptions etc.

Possible GP concerns that you may experience

1. Depending on the business arrangements in your particular practice, GPs may have been receiving a proportion of all nurse and other MBS item numbers billed under their name, and there may be some resentment from non-principal GPs over a potential loss of income. Practices will need to look at their own arrangements to address this.
2. The open- ended nature of the potential role may present some confusion or some anxiety. In our experience, GPs can range from very limited in their ideas of roles for nurses through to GPs who want the nurses to undertake a range of inappropriate activities well outside the scope of the nurse. It will be critical for you to be clear about your

individual scope of practice, your practice population health needs and those activities which would increase access for patients to appropriate services.

Concerns you may have

Change is always accompanied by a slight sense of trepidation for most of us, particularly when the exact policy direction and the likely end points are not clear. We would expect that after having to justify nurses' existence by rigorous attention to the MBS item numbers and the GP Health assessment item number etc, many of you may feel anxious about these changes. You may feel it removes a focus on those things in which you have taken pride in doing well. And we won't be able to externally 'count' what you do, other than achieving outcomes in programs such as the diabetes care package.

Other concerns may be a nervousness about your position if the practice deems the changes to be adversely affecting their practice. Additionally you may feel insecure if are an EN when this package provides additional funding for RNs.

As with any major change, as we wait for more details, it will be critical for you to get an understanding of how this is going to work broadly – but also to not get overly concerned at this stage-implementation is not set until January 2012. Furthermore it would be useful to start constructive conversations with practices in team meetings about what this is all going to mean. We would expect that other organisations such as the AAPM, RACGP and GP Networks will be doing a lot of thinking about business models and we will be liaising with them to make sure we have similar messages going out.

Members with concerns are very welcome to contact the APNA office at any time to discuss concerns or ideas for how to make this work for nurses and their patients.

Embracing the opportunities

We are experiencing a very exciting time for nurses within the general practice environment. The intent of the reform is to increase both the numbers and the role of nurses in general practice. We are thrilled obviously to see so many of the areas where we have been lobbying about current funding initiatives embraced. Recognition of nurses as health professionals in their own right, removal of the 'for and on behalf of' stipulation , allowing nurses to provide comprehensive nursing care and so on are a major step forward.

We look forward to working together with you to get the best outcomes for nursing and patients from these announcements.

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[i] Simoens S, Giuffrida A. *The impact of physician payment methods on raising the efficiency of the healthcare system : an international comparison*. Appl Health Econ Health Policy. 2004;3(1):39-46.