Editorial note:
The authors of this paper have asked to have their names withheld. The JPN editorial team do not usually agree to such requests, but we have made an exception in this case. As you will read, there is significant animosity between Nurse Practitioners and the federal health bureaucracy. Real or otherwise, the authors fear potential reprisals for calling out what they see as prejudicial behaviour against their community.

The good, the bad and the ugly: Nurse Practitioners and the politics of health care

The good

Nurse Practitioners (NPs) are highly educated health care professionals and the only advanced practice nurses recognised and regulated by the Nursing and Midwifery Board of Australia. The purpose of implementing the NP role was to improve the flexibility of the Australian health care system and increase patient access to health care[1]. The endorsement of the first two Australian NPs took place in December 2000, and now over 2200[2] NPs provide comprehensive patient care across a diverse range of health care continuums[3,4]. Through collaborative, safe, and effective care, the NP provides value-based health care across the public and private health care sectors[5].

In 2009, then Minister for Health Nicola Roxon, led historic health reform resulting in the *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010*. This legislation enabled patient access, albeit limited, to the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) for eligible NPs[6]. As a result, private patients choosing to see an NP for their health care can claim limited Medicare subsidies for services and medicines arising from NP-directed care in primary health care settings.

The MBS and PBS reforms have truly been transformative for the Australian NP role. No longer restricted by often rigid public sector NP models of care, that limit nursing scope of practice and innovation[7–9], NPs are increasingly moving to the private sector to actualise the full potential of their roles and explore innovative models of care[10].

The bad

More than a decade later, of the 5700 items listed on the MBS, patients are still limited to a handful of subsidies for NP-directed care[11]. These include subsidies for face-to-face and telehealth consultations, a comprehensive array of diagnostic pathology items, limited diagnostic imaging requests and limited point-of-care tests performed by NPs[11]. Evidence suggests NPs often achieve the same or better outcomes in delivering primary care services compared to doctors[12,13]. Despite this, the Australian government uses taxpayer dollars to increase subsidies for patients seeking care from doctors, thereby giving the medical profession an unfair market advantage over NPs providing those same services. After ten years of participation in the MBS and PBS, there is no evidence that suggests services performed by NPs are inferior, unsafe or ineffective when compared to doctors. One has to ask why the Australian Department of Health (DoH) refuses to broaden the scope of subsidised services offered by NPs. The answer may lie in the lobbying influence of medical associations influencing DoH bureaucrats to assist with turf protection for the financial benefit of doctors and not the benefit of patients[14].

When looking at consultations alone, MBS subsidies are over 50 per cent higher for general practitioners, who are also afforded additional

incentives for 'bulk billing' their patients. Bulk billing transfers the patient's subsidy directly to the health practitioner. No special incentives exist for NPs who bulk bill their patients. Such Australian government policies assure that only the medical profession can provide universal health care through bulk-billed MBS services. The existing MBS subsidies ensure that bulk-billing NPs can neither sustain themselves financially nor practise independently. To maintain financial viability, NPs are increasingly passing the costs of care provision onto patients. In effect, the Australian DoH is consciously shifting health expenses to the consumer regarding NP-related primary health care, as it is nearly impossible for NPs to earn a living on a bulk-billed income alone.

Current MBS subsidies limit patient access to health care and, for some patients, remove the choice of who delivers their health care. Attempts by NPs to change the limited access to the MBS include 14 evidence-informed primary health care recommendations compiled by the Nurse Practitioner Reference Group (NPRG)[15] for the MBS Review. There were also numerous professional body and individual clinician submissions to the MBS Review. In their capacity as representatives of peak professional bodies, NPs and many other nursing leaders met many times with government to lobby for broadening MBS subsidies to address crucial health care shortfalls. All of these attempts have been unsuccessful[16]. Of note, the membership of the MBS Review Taskforce had no representation from the nursing profession and consisted almost entirely of medical practitioners, except for one policy expert and one health consumer. Medical associations representing medical practitioners have clearly articulated their position on the NP role. These positions are not supported with evidence but with the use of misinformation and scare tactics[17–19]. Compounding this situation are press releases outlining how the Australian government and medical associations are working together to co-design administrative processes to support future changes to the MBS, which leaves little confidence that the patients of NPs will receive fair subsidies[20].

The experience of NP surgical assistants also demonstrates the notion of a medico-centric approach to administering the MBS by the Australian DoH. Aside from input into the MBS Review process, the NP surgical assistants have unsuccessfully tried to navigate the Medical Services Advisory Committee (MSAC) process. The role of MSAC is to appraise health care services for public funding[21]. NP surgical assistants have demonstrated they offer an effective[22] and legitimate[23] alternative to medically qualified surgical assistants and increase patient access to surgical care[24]. Yet, attempts to gain access to the MBS surgical assisting patient rebates via applications to the MSAC committee have failed. Both applications failed in the pre-assessment phase. Like the MBS Review Taskforce, the MSAC committee has no nursing representation, with 16 of the current 21 positions occupied by medical practitioners.

At face value, the above observations appear anti-competitive in nature. This proposed anti-competitive culture of the Australian DoH makes one wonder if the *Competition and Consumer Act 2010* applies, or if the powers of the Australian Competition and Consumer Commission (ACCC), the independent statutory authority that enforces the Act, pertain to those administering the MBS. The ACCC is investigating if the Australian DoH has a case to answer. The ACCC has also suggested that the Commonwealth Ombudsman may be an alternative avenue for NPs to consider. The role of the Commonwealth Ombudsman is to assure that Australian Government entities act with integrity, treat people fairly and influence improvements in public administration[25].

The ugly

Failing meaningful intervention from the ACCC or the Commonwealth Ombudsman, the law of torts may be a final possibility. Torts law is concerned with awarding damages to individuals to repair the harm caused by a breach of obligation[26,27]. The tort of misfeasance applies to a person occupying a public office who exceeds or abuses public power[28] or breaches their obligations[27]. Two points for consideration here are:

1. that occupancy of public office implies a public position, but this is not limited to those appointed to a statutory office; there is no definitive test to determine what incorporates public office
2. the notion of public law obligation considers public officials owe a duty of care not to abuse their powers[29].

Misfeasance is 'the wrongful performance of a normally lawful act; the wrongful and injurious exercise of lawful authority'[30]. This tort does not apply to everyone employed by a public authority; the courts have outlined that the public official must have a significant position with relevant power and accountability to the plantiff[27]. To establish the tort of misfeasance, the plaintiff must prove that in the alleged discharge of the public official's duty, their act was invalid or unauthorised, malicious and caused harm to the plantiff[31].

The MBS Review Taskforce aimed to align the MBS with contemporary clinical evidence and practice by providing recommendations for reform to the Minister for Health. The aims were to support affordable and universal access, best-practice health services, value for the individual patient and value for the health care system[15]. The MBS Review Taskforce did not endorse any recommendations from the NPRG but did propose three 'alternative' recommendations without any evidence or rationale to support them. This action was outside the MBS Review's terms of reference and highlighted not only poor Australian DoH governance processes but also the genuinely medico-centric nature of the MBS Review process.

Members of the MBS Review Taskforce were in significant positions of power and had accountability to patients and NPs, not solely medical practitioners. The taskforce was predominately comprised of medical practitioners engaged by a medico-centric DoH.

Members of the taskforce had many opportunities to discuss and engage with NPs and nursing groups, who highlighted the importance of both comprehensive MBS access for patient care and reduced out-of-pocket expenses. The failure of the taskforce members to recognise these highly skilled health care professionals and ignore the evidence they provided has impacted many NPs' mental health. Their primary source of distress relates to their patients who, due to the current MBS restrictions, cannot access subsidised health care and have sometimes experienced unacceptable delays or duplication in care that has contributed to patient harm, as well as breaches in patient confidentiality. Disregarding NPRG recommendations and proposing irrelevant substitute recommendations, knowing these would restrict the NPs ability to provide patient care, may enable action in misfeasance against taskforce members.

Finally, one should note there may be unintended consequences to the staunch resistance of the medical lobby to patient subsidies for NP-directed care. Medical turf protection and non-collaboration may ultimately result in a parallel system of primary health care providers, who actively compete for the patients and businesses of high-paying health consumers. This can be seen with NPs who are turning to niche specialty practices funded solely by out-of-pocket payments because they can't earn a living serving the marginalised populations they were educated and trained to care for. This serves no one, with losers on both sides.

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