New Zealand Nurses Organisation

Submission

on the

Cost of Treatment Regulations

to

Strategy and Policy

Accident Compensation Corporation

June 2005

1.0 Introduction

1.1 The New Zealand Nurses Organisation (NZNO) is pleased to make a submission to the Cost of Treatment Regulations. NZNO represents nearly 40,000 nurse midwives and health care workers and is the leading and largest organisation of nurses in New Zealand. NZNO is committed to health and social policy that best meets the health and social needs of all peoples of New Zealand and to the founding document of New Zealand – Te Tiriti ō Waitangi.

1.2 The New Zealand College of Practice Nurses (NZNO)[1] is one of NZNO's 21 specialty professional groups. The New Zealand College of Practice Nurses has over 2000 members and is a specialty, professional organisation dedicated to leadership, support, education and professional development for practice nurses. NZNO supports the submission (attached) from the College of Practice Nurses who has long standing concerns about the anomalies in ACC fee payments for practice nurse treatments.

2.0 ILO Convention

2.1 NZNO acknowledges the Government's commitment towards compliance with ILO Convention No 17 which requires signatory countries to ensure that the medical costs of work-related injuries are not borne by workers. NZNO shares the Council of Trade Unions (CTU) concerns about the disparity between the actual cost of treatment and the amount contributed by the Government for treatment costs. This difference results in injured workers continuing to pay co-payments for treatment costs.

2.2 While NZNO welcomes increased funding for treatment consultations for a range of providers, we are still concerned about the adequacy to meet the

[1] Henceforth referred to as College of Practice Nurses

ILO requirements to ensure that people do not have co-payments for their treatment costs.

3.0 Fee Structures

3.1 There are two main points of contention. The first is the unrealistically low fee set for nurse visits. Fifteen dollars rarely covers actual costs. The effect of this low fee is an incentive to have a dual medical practitioner and nurse visit to obtain the more realistic claim fee of $ 38.00.

3.2 The second issue is that the very large differential fee between medical practitioner and nurse visits incentivises the practice to construct a medical visit as well so that both the nursing and the medical treatment cost can be claimed. Often in fact the medical treatment is unnecessary. The fabrication of medical costs is an inefficient and unethical practice.

3.3 The Primary Health Care Strategy promotes improved health outcomes and reduced inequalities by offering the general practice team the opportunity to work within differing boundaries. Without fair payment for the nurse treatment services there is no incentive to encourage advanced nursing practice for nurses within primary care in delivering ACC treatments.

3.4 Changes to the fee structure to recognise nurses' skills would also assist with continuity of care. The practice of obtaining a medical check to ensure an adequate payment for the practice means that the patient may see a medical practitioner whom they have never seen before for what is termed a 'medical check". Fair payment costs for the nurse visits would avoid the patient having to be seen (and having to repeat their story) to multiple other providers who have a limited role only in the patient's care.

3.5 The current fee structure provides an incentive for the duplication of work. NZNO submits that funding should provide an incentive for nursing work to be done by nurses and for medical practitioners to focus on the

services in which they are expert. As the College of Practice Nurses proposes, the treatment fee should be calculated on the nature of the treatment rather than the nature of the provider. The New Zealand Nurses Organisation and the NZNO College of Practice Nurses would be willing to work with ACC to identify a range of treatments within the expertise of nurses. Likewise, medical practitioners can develop a range of medical treatments relevant to ACC cases. A realistic fee could then be claimed, by either nurses or medical practitioners.

3.6 Some case studies are presented to demonstrate these anomalies, the inefficiencies and the issues around using nurses' specialist skills.

4.0 Examples

4.1 Suture Removal

4.1.1 A 40 yr old man, who has 5 stitches from a head laceration presents for removal of sutures. The appointment is made with the nurse for the removal of sutures. Although the nurse removes the sutures, a "quick check" is obtained from the medical practitioner.

4.1.2 It is within the scope of registered nurse in a general practice setting to assess the appropriate time for suture removal. The nurse also carries out an assessment for the presence of infection, neurological changes and provides injury prevention education. This adds time to the consultation. The cost of the treatment is more than $15.00. It is unjust for the nurse to be able to claim only the nurse visit claim and is counter to ACC principles and policy.

4.2 Plaster Check

4.2.1 This case study is from an experienced orthopedic nurse working in an accident and medical clinic.

4.2.2 As a matter of protocol and best practice all patients who are fitted with a new cast are asked to return in one week for a "plaster check". Regardless

of the level of experience of the registered nurse involved in seeing the patient for the “plaster check”, a medical practitioner (not necessarily the one who saw the patient the first time when the cast was fitted) is involved with the “plaster check”. In this case the nurse was an orthopaedic nurse with extensive experience in assessing plaster casts, who had significantly more experience than the medical practitioner.

4.3 Wound Care

4.3.1 Wound care is where the anomalies are the most evident. District nurses care for, and treat wounds, that are referred by medical practitioners and from hospital referrals. District nurse care for wounds and obtain medical oversight when they assess this as necessary. In the general practice setting it is also the registered nurse who is normally the primary health professional responsible for wound management. But the experiences of practice nurses are that there are very few occasions when they are not required to have a medical practitioner review a wound, even if there are no signs or symptoms of infection or other cause for concern. Given that the average wound dressing takes about 30 minutes, it is not economical or viable for the visit to be claimed as a nurse only visit. The medical practitioner’s role in the visit is usually minimal and consists of affirmation to the nurse to proceed as she determines best.

4.3.2 There are many treatments in general practice that are best and most efficiently provided by nurses. These include eye injuries, simple sprains, and injuries requiring rest; compression; ice and elevation, obvious fractures requiring x-ray, strapping and compression therapy. These services are appropriately provided by nurses but should command an appropriate and realistic ACC fee

4.4 These are just three examples of common situations that occur in general practice that relate to the fee differential between medical practitioner and nurse visits. This differential fee between nurse and medical practitioner visits results in nurses’ skills and experience not being recognised or

rewarded and inefficient practices to obtain reasonable payments, and to keep co-payments lower.

4.5 NZNO recognises the need to ensure that the appropriate incentives and fees structures are in place. A fee system, however, should be based on fairness and efficiency and cover the real cost of the treatment to provide the best service for the person to meet their health needs.

4.6 The difference in treatment fees between medical practitioners and nurses is a reflection of historical inequities and does not recognize nurses' advanced training skills, professionalism and clinical autonomy.

4.7 NZNO supports further discussion on the nurse and medical practitioner fee structure to occur at the ACC nurse liaison and ACC GP liaison advisory groups.

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Whilst the New Zealand College of Practice Nurses (NZNO) agrees that "for some claimants, high co-payments may create a financial barrier to accessing treatment, which can be detrimental to the success of their rehabilitation", the means by which ACC has addressed this issue is flawed in respect to nurses, and indicates a misunderstanding of the professionalism, team work, expertise and responsibilities of practice nurses, in particular, within the general practice team.

Practice nurses are well-trained and very experienced, in wound care in particular. In many general practices it is the practice nurses who manage wound care for patients, and only refer to a general practitioner when there is need- e.g. infection requiring medication or non responding wound requiring referral to specialist etc. The way that ACC has formulated the treatment costs has undermined the expertise and autonomy of practice nurses by paying *a provider* for the service rather than the service provided, regardless of who provides that service within the team.

The current treatment regulations fee schedule induces general practitioners to adopt the practice of seeing every patient who has an injury, whether or not this is required, to gain the full nurse/doctor combined fee. This practice ignores the fact that the practice nurse is very often the main treatment provider managing the wound. The patient is seen more often than is required, as general practitioners are often not as experienced in wound care products and their use, and the professionalism and expertise of the nurse is undermined in the patients view, by the general practitioner insisting on seeing every wound, every time, merely for the fee, with no explanation of this strategy to the patient.

The same comments can be extrapolated for plaster care and other follow up consultations with respect to injuries covered by ACC.

The NZCPN, NZNO recommend that the nurses cost of treatment regulations fee be the same as the general practitioners fee for some services, e.g. wound care, and that the treatment costs to be changed are debated and discussed with the ACC nurse advisory group as well as the ACC GP liaison advisory group.

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