19 September 2014

Select Committee on Health
The Australian Senate
PO Box 6100
Parliament House
CANBERRA ACT 2600

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To whom it may concern

Submission to the Select Committee on Health

Attached please find our submission to the Select Committee on Health. The six nursing organisations whose logos are included in this letter contributed to this submission and endorse its content. I am signing this letter on behalf of these nursing organisations. Please direct any future correspondence with the contributing nursing organisations through me:

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Please do not hesitate to contact the participating nursing organisations for any further discussion relating to this submission through this office. We look forward to the outcomes of this inquiry.

Yours sincerely

Adjunct Professor Debra Thoms FACN (DLF)
Chief Executive Officer
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the Australian College of Mental Health Nurses Inc. | Australian College of Midwives | ACN | apna Supporting nurses in primary health care | CATSINaM | CRANAplus improving remote health

Submission to the Senate Select Committee on Health

Inquiry into Health Policy, Administration and Expenditure

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19 September 2014

This submission to the Select Committee on Health's Inquiry on Health Policy, Administration and Expenditure was jointly prepared by the Australian College of Nursing (ACN), the Australian College of Mental Health Nurses (ACMHN), the Australian Primary Health Care Nurses Association (APNA), the Australian College of Midwives (ACM), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), and CRANAplus.

The following signatures represent the formal endorsements from each organisation.

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Our organisations

Australian College of Nursing (ACN)

ACN is the national professional organisation for all nurse leaders. ACN is an advocate for the nursing profession, advancing the skills and expertise of nurses to provide leadership in their contribution to the policy, practice and delivery of health care. ACN is a membership organisation with members in all states and territories, health care settings and nursing specialties. ACN's membership includes many nurses in roles of influence, including senior nurses, organisational leaders, academics and researchers. ACN is also the Australian member of the International Council of Nurses headquartered in Geneva.

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) was founded in 1997. It is the national peak body that represents, advocates for and supports Aboriginal and Torres Strait Islander nurses and midwives at a national level, and to close the gap in health for Aboriginal and Torres Strait Islander people. We are a membership-based organisation and are governed by a nationally elected Aboriginal and Torres Strait Islander Board.

Australian Primary Health Care Nurses Association (APNA)

Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care including general practice. With 4000 members, APNA provides primary health care nurses with a voice, access to quality continuing professional development, educational resources, support and networking opportunities. APNA strives to increase awareness of the role of the primary health care nurse, and to be a dynamic and vibrant organisation for its members.

CRANA*plus*

CRANA*plus* is a national member-based organisation and the peak professional body for remote and isolated health. The purpose of CRANA*plus* is to represent, educate, and support the people providing health care services in remote and isolated regions of Australia. In 2008 the Council of Remote Area Nurses changed to better reflect the work of the organisation, that being to work with all people within the context of remote and isolated practice, not any one specific professional discipline. As a result CRANA became CRANA*plus* and opened its doors to become multi-disciplinary. CRANA*plus* is guided and governed by a volunteer board of nine Directors.

Australian College of Mental Health Nurses (ACMHN)

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. Mental health nurses work in mental health across a

variety of settings – acute psychiatric units in hospitals, specialist community mental health teams, general practices, emergency departments, as well as in policy, administration, management and research roles. Mental health nurses as individuals and a profession are a key component of Australia's mental health care system. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The College also sets standards of practice for the profession and promotes best practice of mental health nursing.

Australian College of Midwives (ACM)

The Australian College of Midwives (ACM) is a national, not-for-profit organisation that serves as the peak professional body for midwives in Australia. The ACM is committed to being the leading organisation shaping Australian maternity care, to ensure the best possible maternity outcomes for all Australian women. It is guided by research evidence that pregnant women and mothers benefit from having access to midwifery care throughout their childbearing experience.

Recommendations

The nursing and midwifery organisations that are co-signatories to this submission recommend that governments:

- Reform the fee-for-service funding model to better support the ongoing, multi-disciplinary care people with chronic illnesses require. Funding models should deliver values centred incentives, connect primary health care to other sectors of the health care system and spur innovation.
- In the interim, until funding reform is achieved, provide additional funding streams to increase access to nursing and midwifery services. Options include increasing the number and value of MBS items for nurses and midwives and the provision of grants or block funding for the provision of much needed nursing and midwifery services.
- Strengthen primary health care by supporting nurses and midwives in primary health care to implement models of care such as nurse-led clinics and caseload midwifery.
- Continue to support and invest in eHealth systems to realise better service coordination and integration and to cut waste.
- Invest in and coordinate a stronger approach to addressing the social determinants of health to achieve population health equality and health system sustainability.
- Support future nursing and midwifery supply by investing in nursing and midwifery leadership programs to produce leaders able to better support care delivery operations, improve productivity and workforce retention.
- Enhance workforce flexibility through funding formalised transition support for nurses and midwives who change clinical area or move to areas of need.
- Support the development and implementation of inter-professional education models for health care professionals to support multidisciplinary care by breaking down professional silos.
- Introduce the requirement that cultural safety training must be provided to staff as part of the accreditation process for health services.
- Introduce the requirement that health services are provided in a culturally safe environment for the benefit of patients and staff.

Introduction

The Australian College of Nursing (ACN), Australian Primary Health Care Nurses Association (APNA), Australian College of Mental Health Nurses (ACMHN), Australian College of Midwives (ACM), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), and CRANA*plus* are pleased to provide this joint submission to the Senate Select Committee on Health's *Inquiry into Health Policy, Expenditure and Administration.*

Australia possesses a world-class health system that has delivered high-quality, largely equitable care to its population for many decades. It has been a major contributor to the high life expectancy and high quality of life that most Australians enjoy today. However, shifting pressures – particularly those associated with an ageing population, high levels of chronic disease, and expensive health technologies – are placing significant strain on its capacity and resources.

This strain is manifesting itself through ostensible health inequality, particularly between Indigenous and non-Indigenous Australians, large and increasing demands on government spending, and health workforce pressures.

These issues are symptoms caused by a broader and more complex set of underlying factors, which at their heart include:

1. An unbalanced health system that is geared towards episodic, treatment-based medical care rather than comprehensive primary health care, which is where the demand and necessity lies.
2. A Medicare Benefits Schedule (MBS) that impedes equitable access to care and promotes service inefficiency.
3. An inability, to date, to comprehensively meet Australia's health workforce needs.

This submission discusses these issues in detail from a nursing and midwifery point of view. In addition, it recommends solutions that, if adopted, will go a long way in helping governments realise a more effective, efficient, equitable, and sustainable health system.

Nurses and midwives represent the largest health workforce in Australia, consisting of more than 362,000 registrants[1]. These professionals work at the 'coal face' of Australian health care. Nurses and midwives are spread in great numbers across the country, and they possess possibly the widest skills set amongst the health professions.

This becomes evident when considering that nurses and midwives operate in all geographical areas (metropolitan, regional, rural, and remote), within many specialisations (e.g. mental health, dementia, diabetes), and across many sectors and settings (primary, hospital, outpatient, communities, aged care, social welfare, schools, public and private).

[1] Australian Health Practitioner Regulation Agency (AHPRA). Nurse and Midwife Registrant Data June 2014.

Nurses and midwives are well placed to inform health system reform. In addition to the vast practical knowledge they gain through the breadth of their experience, many nurses and midwives are highly-skilled, multi-disciplinary researchers, with increasing numbers engaging in PhD and post-doctoral research programs.

Moreover, their skills, experience and critical function within the health system makes them essential to any health reform implementation. The large volume of the nursing and midwifery workforces and their spread across services and geographically means that even small improvements in the efficiency and quality of their services have a significant system-wide effect. It also means that nursing and midwifery support provides a substantial return on any government investment. The participation of nurses and midwives in this inquiry, along with any subsequent health reform activities, is therefore paramount to securing the effectiveness and sustainability of Australia's health system.

This submission was developed in wide consultation with nurses and midwives. It articulates the key barriers to efficient, high-quality health care as nurses and midwives experience them in their every day delivery of care. In considering both the professions' input and the terms of reference (ToR) of this inquiry, this submission identifies four key areas that we believe require the Senate's attention. These areas cut across all of the ToR and provide the Committee with the information needed to fulfil its mandate of making recommendations for effective and prudent health system reform. These areas are:

- Equitable access to health care
- Prevention, health promotion, and early intervention
- Integration and coordination
- Health workforce planning

1. Equitable access to health care

State and federal governments are responsible for ensuring that everyone has equitable access to health care. This is attained when health services are affordable, timely, of high-quality, and responsive to everyone's needs, including cultural, language, and religious requirements. Equitable access to health care is both ethically and socially desirable because it enables people to:

- Lead socially, culturally, and economically productive lives
- Realise their physical, social, psychological, and cultural potential
- Experience quality health outcomes.

In addition to its ethical and social attributes, equitable access to health care also presents a strong economic case. Inadequate access leads to poorer population health outcomes, lower labour force

participation, lower productivity, and reduced income and consumer demand. These effects may in turn contribute to a higher reliance on government support[2].

While the importance of equitable access to health care is widely understood, Australia still has some work to do if it is to fully realise this benefit for all people. Some populations in particular experience greater challenges than others in accessing health services, and each of these challenges may be unique to particular groups. For example, Aboriginal and Torres Strait Islander people may have difficulty in accessing care that is culturally safe, people living in rural and remote areas may face challenges associated with distance and service availability, people suffering from a mental illness might not have the necessary support to help them access the correct services, and those on low incomes may face cost barriers to accessing necessary care.

Aboriginal and Torres Strait Islander peoples face particularly stark challenges in accessing health services, and these challenges, along with their poorer health outcomes generally, can largely be attributed to their social determinants of health[3,4]. The social determinants consist of measures such as education, employment, income, housing, access to services, social networks, connection with land, racism, and incarceration. On all of these measures, Indigenous people suffer substantial disadvantage. The National Aboriginal and Torres Strait Islander Health Plan envisions a health system that is free of racism and inequality, and which enables all Aboriginal and Torres Strait Islander people to gain access to health services that are effective, high-quality, culturally-safe and affordable.

To achieve this vision it is imperative that all health professionals understand the impact that past governmental policies and cultural practices have had on Australian's First Nations People. It is equally important that policy makers and health professionals realise that Australia's health system is not structured in a way that is conducive to comprehensive Aboriginal and Torres Strait Islander wellbeing. It is an individualised, medical-centric model which poorly services the social and emotional wellbeing vital to the Aboriginal and Torres Strait Islander people's communitarian, holistic health centred culture. Appropriate cultural safety education and ongoing continuing professional development is a key element to achieving the vision set out in the National Aboriginal and Torres Strait Islander Health Plan. It is also important that the National Aboriginal and Torres Strait Islander Health Plan is embedded in any future related health system reform.

Australians living in rural and remote areas similarly face challenges in accessing a comprehensive suite of health care services. Research undertaken by the National Rural Health Alliance (NRHA), in partnership with the Australian Institute of Health and Welfare (AIHW), finds that rural and remote

[2] Australian Institute of Health and Welfare 2009 Chronic disease and participation in work.

[3] Carson B, Dunbar T, Chenhall RD, Bailie R, eds. (2007). Social determinants of Indigenous health. Crow's Nest, NSW: Allen and Unwin.

[4] Marmot M (2004). The status syndrome: how social standing affects our health and longevity. New York: Holt Paperbacks; Wilkinson R, Marmot M (2003) Social determinants of health: the solid facts. Denmark: World Health Organization

Australians have a shortfall of more than 25 million health services per annum[5], despite there being a greater need due to higher levels of chronic disease and associated risk factors in these areas. These issues manifest themselves in the fact that rural and remote Australians have lower life expectancies and poorer health outcomes than their city counterparts[6].

Marginalised groups such as the physically and cognitively disabled, homeless, migrants and refugees are also populations who can find accessing health services difficult. Their reasons for experiencing these difficulties can vary widely. However issues regarding health literacy, language and cognitive barriers, mental health, social stigma, and lack of financial means are all relatively common. Without the correct and adequate support for these vulnerable populations, many will continue to miss out on the services they need, placing them, their families, and the broader community at greater risk.

1.1 Barriers

There are many reasons as to why people have difficulty in accessing necessary health services, including service unavailability, high-costs, and inefficient use of the health workforce.

1.1.1 Service unavailability

The most significant barrier to rural and remote residents accessing health services is the general lack of service availability. There are simply not enough services available to meet the needs of these populations in a timely manner, meaning they receive intermittent or delayed care, with a heavy reliance on fly-in-fly-out (FIFO) workers, or they travel long distances to receive necessary care. This inequitable access is contributing to the poorer health outcomes that rural and remote residents experience, and it is a major factor driving up unnecessary hospital use and health care costs. It is also responsible for poor care continuity, which contributes to greater service errors, inefficiencies, and low consumer satisfaction.

In addition to the general shortage of health services in rural and remote Australia, the types of services available is another important factor driving inequitable access. People living with serious and continuous mental health conditions, for example, are often unable to access the types of service they require at a particular point in time, contributing to avoidable health deterioration and increased costs. Many people with mental illness can be left untreated in the community until their condition worsens to the point where they need to be admitted to an intensive mental health unit, simply because a primary mental health service was not available when it was needed. And this example can be applied across many different conditions and situations. For this reason, strategic service planning, where investment and support matches population health needs and user preferences, must be undertaken when designing and implementing health services policy.

[5] National Rural Health Alliance, 2011. Fact Sheet: The extent of the rural health deficit.
[6] AIHW (2014). Rural Health Life Expectancy. Accessed 18 September 2014. Available at: http://www.aihw.gov.au/rural-health-life-expectancy/

1.1.2 Health workforce availability

Inadequate health service availability in rural and remote Australia is driven by a number of factors including insufficient infrastructure, transport, and general employer and employee supports, and shortages in the health workforce. However, a poorly balanced skills mix is the most significant driver of this issue. There are particularly stark shortages of specialist health professionals in rural and remote Australia, especially doctors. This means that rural and remote nurses and midwives have to take on much higher levels of responsibility than their urban counterparts. Without them doing so, timely provision of essential services in the bush would be almost impossible.

Despite their critical role in providing these services, nurses and midwives are not provided the recognition that is needed to attract and maintain them into these positions. For example, the federal government has put a number of financial and other supports in place for doctors to practice in rural and remote areas, yet these supports have not been extended to nurses and midwives. In addition to general location-based incentives, there are a lack of incentives and support to encourage nurses to gain specialist skills in high-need areas, such as in primary health care, mental health, midwifery, aged, and dementia care.

Nurses and midwives with specialist skills are able to provide critical services to patients in areas where they would not otherwise exist. This greatly improves their access to such services by reducing wait times and negating the need to travel long distances. It also takes much of the strain off doctors who have to travel for exorbitant periods of time to meet the needs of rural and remote residents.

The Aboriginal Medical Services (AMS) workforce is also crucial to providing equitable access for Aboriginal and Torres Strait Islander peoples, especially those who live in rural and remote areas. Yet they are facing an uncertain future with ambiguity surrounding their future funding. It is critical that this sector's funding continue with some certainty so that Aboriginal and Torres Strait Islander peoples can continue receiving timely care, and so that they can more easily retain existing relationships with their providers. This is especially important given the role that trust plays in Aboriginal and Torres Strait Islander people's decisions to seek care. It is well acknowledged that Aboriginal and Torres Strait Islander people achieve better health outcomes when Aboriginal and Torres Strait Islander health professionals care for them. The National Aboriginal and Torres Strait Islander Health Plan highlights this, with particular reference to its criticality in addressing the high rates of chronic disease in Aboriginal and Torres Strait Islander communities.

The aged care workforce is another area requiring significant government attention if it is to provide equitable access to health care for older Australians both now and into the future. There is a strong need for more registered and enrolled nurses to be employed in aged care, where they have the specific skills to effectively and comprehensively meet the health and social needs of older Australians. This issue will become particularly stark as Australia's ageing population creates an inverse effect, where more aged care services will need to be provided by a smaller workforce. Without the correct and adequate incentives and supports in place to attract and retain nurses in

the aged care sector, older Australians will increasingly experience inequitable access to care, and with that, poorer health outcomes.

1.1.3 Out-of-pocket expenditure

Health service affordability is a significant impediment to the achievement of equitable health care access in Australia. Australia ranks 7th highest in out-of-pocket health care expenditure in the OECD (out of 34 countries), with consumers paying an average of $731 per person, per annum[7].

Individuals pay these costs across many parts of the health system, including in general practice, medical specialist and dental services, and when purchasing prescription medicines. The fact that these costs are impeding equitable access to health care is evidenced by the number of people who report delaying or neglecting to see a health professional, or purchasing prescription medicines, because of cost. The percentage of adults who delayed or did not see a general practitioner, medical specialist, or dental professional reached as high as 13%, 14%, and 34% in some areas, respectively. While the percentage of those who delayed or did not purchase a prescription medicine because of cost reached as high as 15%[8].

Partly driving up costs for consumers is their inability to receive a rebate for many of the services provided by nurses and midwives. While many regular health services can be undertaken by nurses or midwives alone, such as wound care, chronic disease management, and early childhood health checks, the current MBS system only subsidises the doctor to perform them. If nurses and midwives were provided with more appropriate access to MBS items, they could provide these services for less than a doctor typically charges, meaning a lower or no co-payment for the consumer, and in turn, more equitable access.

1.1.4 The health budget

Another factor driving high out-of-pocket expenditure is the fact that the government's health budget is finite, and currently unable to meet the level of costs necessary to keep people from delaying or foregoing care because of cost. Government therefore concerns itself with how to either reduce the costs of care, or increase the amount of funding available for it, or both. This is a complex issue that requires a level of analysis and discussion beyond the scope of this submission. However, logic suggests that a more balanced health system, one where conditions are treated in the appropriate setting, i.e. where primary health related conditions are treated in the more efficient and cheaper primary health care setting, could provide substantial savings to government.

The fact that hospitals are being unnecessarily overused in Australia to treat primary health care related conditions is evidenced by the fact that there were over 635,000 potentially avoidable hospital admissions in 2011–12. Together they accounted for 7% of all hospitalisations in that year,

[7] OECD. Health Statistics: Health expenditure, 2014.
[8] National Health Performance Authority. Healthy Communities: Australians' experience with access to health care 2011-12.

and represented almost 2.5 million hospital bed days or 9% of all hospital bed days[9]. Diabetes related care, an exemplar of inappropriate hospital use, saw a 116% inpatient hospital expenditure increase between 2000-01 and 2008-09, growing from $300 million to $647 million in costs [10]. If the health system were more appropriately used, substantial savings could be reinvested back into the health system, reducing out-of-pocket expenditure for consumers and contributing to more equitable health care access.

1.1.5 Inefficient use of the health workforce

Inefficient use of the health workforce is contributing to all of the abovementioned issues; namely, service unavailability, an unbalanced skills mix, out-of-pocket expenditure, and pressure on the health budget.

The health workforce is being used inefficiently whenever nurses and midwives are constrained in their ability to work across their full scope of practice. This is being caused by regulatory restrictions, role ambiguity and a lack of support and leadership from government. Examples of where this is occurring include:

- In mental health where mental health nurses are prescribed an unnecessarily narrow scope of practice under the Mental Health Nurse Incentive Program. The functions of credentialed mental health nurses working in primary health care under this program are said to include monitoring of a patient's medication and mental state, but fail to include the provision of psychotherapy. This is a wrongful omission that fails to take into account the full breadth of skills and qualifications held by credentialed mental health nurses. As a result, people in need of psychotherapy are missing out on these services when they need not be.
- Many nurses working in general practice are being confined to basic task-based work when they could be delivering higher-level health care including chronic disease coordination, specialist nurse clinics in areas such as asthma and arthritis management, and complex care for older Australians.
- Midwives in private practice are being denied collaborative arrangements and access agreements to hospital maternity units, meaning mothers and babies are being unnecessarily denied midwife-led care.
- Remote and isolated nurses are often being restricted in their practice by the inconsistency in states' and territories' Drugs and Poisons Acts, with some legislation simply not keeping up with the evolving role of remote and isolated nurses in these areas. In addition to creating compliance and educational preparation barriers, it is unnecessarily impeding access to a number of nursing services for many remote residents.

[9] National Health Performance Authority (2013) Healthy Communities: Selected potentially avoidable hospitalisations

[10] Australian Institute of Health and Welfare (2013). Australian diabetes expenditure 2008-09.

1.2 Nursing and midwifery professions' roles in realising equitable access

1.2.1 Working across the full scope of practice

Supporting nurses and midwives to work across their full scope of practice would help address much of the inequitable access being experienced in Australia. It would do this by helping to address many of the problems identified above, such as by opening up access to a greater number services, allowing for the correct services to be provided at the right time, and reducing the cost barriers associated with out-of-pocket expenditure and health budget pressures.

Example:
In Melbourne's western suburbs, a mental health nurse practitioner runs a suicide/self-harm outpatient service offering follow-up support to clients who present at emergency departments with suicidal ideas and/or self-harm for the first time. Access to early intervention and care continuity, as is provided through this service, reduces the likelihood of a patient returning to hospital, which both reduces costs to the health system and provides a better patient experience.

Reform to the midwifery sector also has the potential to increase access to services for women, as well as for reducing costs to the health system.

Example:
Australia adopts a comparatively stronger medical intervention model for its midwifery services than many other countries, costing the health budget relatively higher amounts, unnecessarily. As an alternative to this, the midwifery profession developed the caseload midwifery model of care for pregnant women. In this model, women receive continuity of care from a named midwife (and a back-up midwife) during pregnancy, labour and six weeks after giving birth. Caseload midwifery demonstrates excellent outcomes for women under multiple conditions, including with and without risk factors.

An Australian randomised controlled trial compared outcomes and costs between the caseload midwifery model and standard maternity care. Women cared for through the caseload model had less elective caesarean sections than women receiving standard care. The caseload model achieved quality outcomes equal to standard maternity care. Still, the total cost per woman was $566.74 less for caseload midwifery than for standard maternity care[11].

[11] Tracy, K,S, Hartz, D,L, Tracy M,B, Allen, J, Forti, A, Hall, B et al. 2013 'Caseload midwifery versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial.' *The Lancet* vol. 382, pp.1723-1732.

1.2.2 Delivering services in high-need areas

Nurses and midwives have the potential to improve equitable access to health care by applying their vast, and often specialised skills sets, in areas of high-need, such as aged care, dementia care, refugee health, and Aboriginal and Torres Strait Islander health.

Example:
Adequately educated nurses and midwives have the potential to reduce maternal death rates amongst Indigenous women, and to lower perinatal death rates and increase birth weights of Indigenous babies – if supported to increase access to maternal services in Indigenous communities. Maternal death rates are three times higher in Indigenous women than non-Indigenous women[12]. Indigenous women are also three times more likely to die of conditions related to pregnancy, including within the first 42 days following pregnancy[11]. The proportion of low-birth weights and perinatal death rates are both twice as high for Indigenous babies than for non-Indigenous babies[13]. To improve maternity services and health outcomes for Aboriginal and Torres Strait Islander mothers and babies, it is imperative that access to proven models of midwifery and maternity care is expanded.

1.2.3 Reducing health care costs

Nurses and midwives can lower out-of-pocket costs for consumers by providing services that are often unnecessarily reserved for doctors, at a lower cost than that charged by doctors. Reduced out-of-pocket costs will provide consumers with easier access to care when they need it, rather than delaying or neglecting care as is currently the case. For this to occur, nurses and midwives need greater access to MBS items, and work needs to be done to shift cultural barriers that currently stand in the way of nurses and midwives playing a more autonomous role in service delivery.

1.3 Policy enablers

Government has a number of policy enablers at its disposal that could be implemented to improve population health care access. Following from the discussion above, two of the most significant enablers would include funding and workforce reform, which would help ensure that nurses and midwives are able to work across their full scope of practice, opening up more services, and creating greater system efficiencies.

[12] Johnson S, Bonello MR, Li Z, Hilder L & Sullivan EA. 2014. Maternal deaths in Australia 2006-2010. Maternal deaths series no. 4. Cat. no. PER 61. Canberra: AIHW.
[13] Li Z, Zeki R, Hilder L & Sullivan EA 2013. Australia's mothers and babies 2011. Perinatal statistics series no. 28. Cat. no. PER 59. Canberra: AIHW.

1.3.1 Funding reform

Australia's current health care funding model, as it includes both the MBS and funds provided to, and spent by, the states and territories, needs to be reviewed and reformed.

The fee-for-service model such as the MBS encourages a greater number of patients to be seen on a face-to-face basis. However, MBS funding tends not to encourage coordinated, multidisciplinary care and the linking of a range of services, including social services required by people with chronic conditions and the very old. This model of funding also fails to deliver values centred incentives i.e. incentives that support patients' good health outcomes. Alternative funding mechanisms for care need to be developed and implemented. Any redesign should put the patient at the centre of the design process to ensure funding models promote care that is patient-centred and holistic. As such, any new system of funding should focus on the sickest patients and aim to connect the different sectors of the health care system. Payment reform should also seek to spur innovation and accommodate communication technologies such as email consults and care delivery through telehealth. Mixed funding models that include capitation funding, grants and outcome based payments should be considered.

Financing reform must acknowledge the autonomous scope of practice of nurses and midwives, and discontinue existing arrangements that impose restrictions on their ability to practice without the supervision of medical professionals (e.g. nurses in general practice), or under a written collaboration agreement with a medical professional or health service (e.g. nurse practitioners and privately practicing midwives). Such arrangements are not imposed on any other health professional and their imposition on nurses and midwives is unnecessary and detrimental to equitable health care access. To complement this, a combination of practitioner and organisation based payments should be examined.

In the interim of a full funding system review a number of funding models could be introduced to address barriers to access to care by funding nursing and midwifery services. One option is to expand the availability and value of MBS items for nurses and midwives so that they are better able to provide patients with more treatment options, and reduce the need for many people to see a doctor unnecessarily. Currently, inadequate access to, and value of, MBS items makes it unviable for nurses, nurse practitioners and midwives to practice privately. Another option available to governments is the provision of grants or block funding to nurses and midwives to fund their service provision.

Increasing financial incentives for general practices to employ more practice nurses is another important step in improving access. This would include an increase in funding under the Practice Nurse Incentive Program (PNIP) which is currently inadequate. Creating a funding mechanism to directly remunerate nurses who provide services in the primary health care setting, i.e. not channel it through a medical professional or medical practice, would also help to recognise and promote the role of nurses in delivering crucial primary health care services. This would increase access by providing more options for consumers to seek relevant care, in addition to reducing costs through

greater efficiency, and reducing the need/incentive for patients to attend hospital for minor conditions.

2. Illness prevention, health promotion, and early intervention

Effective illness prevention, health promotion, and early intervention is critical to Australia's long-term health, and therefore to the sustainability of its health system. Preventing people from developing disease in the first place, as well as mitigating the effects of it following its onset, is the most cost-effective and socially preferred method for achieving good population health outcomes.

A failure to adequately undertake preventative health measures can in many ways be apportioned to the high and growing rates of chronic disease in Australia. Chronic diseases are now responsible for 90% of all deaths in Australia, and are the leading cause of illness and disability. The four most prevalent chronic diseases are cardiovascular disease, circulatory diseases (both of which are often complications caused by diabetes), oral health, and chronic obstructive pulmonary diseases. In 2008-09 these conditions cost the Australian Government more than $27 billion in direct health care costs; equating to almost 36% of all allocated health expenditure[14].

In addition to the direct health care costs, chronic disease also attracts significant indirect costs through lost productivity. The AIHW reports that people with chronic disease are 60% more likely to not participate in the labour force, are less likely to be employed full-time, and are more likely to be unemployed, than those without chronic disease[15]. A lower capacity to work can also be associated with a higher reliance on government assistance, which further compounds the direct health care costs and lower economic productivity associated with chronic disease. Therefore, developing and implementing public health policy to reduce the rising incidence of chronic disease in the Australian population must be a high priority for governments.

2.1 Barriers

One of the most significant barriers to addressing chronic disease is the health system's orientation towards episodic, treatment-focused care, delivered predominantly in the acute/tertiary setting. Prevention, health promotion, and early intervention is the principal domain of primary health care, yet government investment and policy focus remains in the hospital sector.

This is evidenced by the fact that hospitals are the largest and fastest growing health spending category in Australia, receiving $18 billion more last year in real terms than they did a decade ago – a 95% increase. While primary care and medical services, including Medicare, grew by a much smaller 60%, or $11 billion over the same period[16]. This is despite the fact that chronic disease, which is more appropriately and cost-effectively treated in primary health care, is the largest disease burden

[14] AIHW 2014. Australia's Health 2014.
[15] AIHW 2009. Chronic disease and participation in work. Cat. no. PHE 109. Canberra: AIHW. Viewed 12 September 2014 <http://www.aihw.gov.au/publication-detail/?id=6442468211>.
[16] Grattan Institute. Budget Pressures on Australian Governments, April 2013.

in Australia. Moreover, the illness prevention and health promotion services delivered in primary health care reduce the need for patients to attend hospital in the first place, in turn reducing the need for such vast levels of investment in the hospital sector.

Example:
Mental health services are often designed to treat people with severe illness, while often failing to provide sufficient monitoring, early intervention, and follow-up services. If these services were in place, health deterioration could be prevented and the need for the patient to be admitted to an acute care setting could in many cases be avoided.

Inadequate investment in illness prevention and health promotion is further reflected in the insufficient incentives and supports for nurses and midwives to provide this type of care; whether it be in general practice or community health. In particular, the primary health care nursing and midwifery workforce lacks career structures and professional roles that offer professional challenges and career development. Nurses working in general practice, and those who want to work in general practice, are also constrained by the Practice Nurses Incentive Program (PNIP), which is inadequate to build up and maintain a nursing workforce large enough to meet Australia's illness prevention and health promotion needs.

Similarly, inadequate access to, and the low value of, MBS items for nurse practitioners and midwives stymies their opportunity to work viably in the primary health care setting. An absence of these attraction and retention factors seriously undermines these providers' capacity to deliver preventative health care.

An inadequate commitment by government to address the social determinants of health (SDH) is another factor contributing to high levels of chronic disease and health outcome inequality in Australia. The SDH are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources, which are themselves co-determined by public policy[17]. Addressing the SDH requires a whole-of-government response, including cooperation and coordination among a wide range of sectors and portfolios, such as health, education, agriculture, industrial relations, and infrastructure and planning.

2.2 Nursing and midwifery professions' roles in realising health promotion, illness prevention, and early intervention

Nurses and midwives play a critical role in providing illness prevention, health promotion, and early intervention services. Nurses in particular play strong leadership roles in areas such as child development and family health, community health, cancer screening, cardiovascular disease risk assessments, and diabetes management. Midwives are critical in the delivery of preventative maternity and early childhood care, such as through undertaking perinatal mental health

[17] World Health Organisation. Health Topic: Social Determinants of Health.

assessments. Ample opportunities exist for nurses and midwives to further expand their contribution in these areas.

Nurses possess the skills to deliver comprehensive chronic disease prevention and management in the primary health care setting. They are particularly well-skilled at educating patients about self-management, and in monitoring and providing feedback on patients' progress. Nurse-led chronic disease management, where doctors play a supportive role, is being utilised more effectively and efficiently in areas outside of Australia – especially in the UK and NZ[18].

Example:
Research undertaken on a nurse-led diabetes clinic in the UK shows that patients demonstrate improved medication adherence and lower HbA1c levels compared to those who attended a general practitioner-led clinic semi-annually. In the UK, nurse-led models of care also exist for chronic cardiac failure, asthma, and Chronic Obstructive Pulmonary Disease (COPD).

Nurses and midwives also play an essential role in addressing the SDH by taking a holistic approach to care, such as through advocating for clients affected by poverty or other social disadvantages, and connecting them to needed services and support. For example, midwifery-led antenatal care provides a key preventative health service that reduces maternal death rates by screening for socioeconomic conditions likely to impact on health outcomes.

Example:
Nurse home visits to mothers during their pregnancy and their child's infancy have shown to benefit the mother's parenting abilities, leading to improvements in the child's mental health and academic performance up to age 12 years. The effect was most significant for mothers and children from the most disadvantaged groups. Interventions focus on improving pregnancy outcomes, child health and development, and economic self-reliance[19].

2.3 Policy enablers

2.3.1 Funding reform

It is critical that the government increase incentives for general practices and other primary health care providers to employ nurses and midwives who can deliver preventative health services. The current MBS funding model does not provide sufficient incentive for primary health care providers to deliver illness prevention, health promotion, and early intervention. Mixed funding models as

[18] Hoare, K,J, Mills, J, & Fancis, K, 2011 'The role of government in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: an adapted realist review.' *Journal of Advanced Nursing* vol. 68, no.5, pp.963-980.
[19] Kitzman,HJ, Olds,DL, Cole,RE,etal. 2010 'Enduring effects of prenatal and infancy home visiting nurses on children: follow up of a randomized trial among children at age 12 years.' *Archives of Paediatric Adolescent Medicine* no.164,pp.412-418.

discussed in the section dealing with Equitable Access are better suited to encourage the delivery of health promotion and prevention.

The current value and number of MBS items also makes it financially unviable for nurse practitioners and privately practising midwives to practice in private primary health care settings. As a result, they are often driven into acute/tertiary care settings. While illness prevention, health promotion, and early intervention also occurs in the tertiary setting, its effectiveness is likely to be greater in community settings where people's health conditions can be dealt with early and more efficiently. While this submission supports a full review and reform of primary health care funding, an interim measure to help improve health promotion and disease prevention would be to increase the value and number of MBS items available to nurse practitioners and privately practising midwives or provide alternative funding models such as block funding for a measurable level of service delivery.

2.3.2 Nursing and midwifery professions' roles in addressing SDH

Greater support for nurses and midwives to work in primary health care would also play a role in helping to address the SDH. This support could be achieved through additional funding for primary health care providers (such as Primary Health Networks) which deliver health care to socially disadvantaged areas. This funding would pay for the extra time nurses and midwives require to work with patients in identifying their comprehensive needs. The additional funding would also give nurses and midwives a mandate to work with providers across different sectors to assist patients with complex health and social needs. Investment in primary health care services to target the alleviation of social disadvantage through programs such as home visiting nurses would yield generous long-term returns to individuals and society.

2.3.3 Other institutional supports

Health service governance frameworks could be designed to give nurses and midwives a more active role in decisions regarding illness prevention, health promotion, and early intervention services. Key performance indicators measuring activities and outcomes in these areas could also be introduced. These data could be used to critically examine the successes and failures of particular interventions, which would continue to build practical expertise in the area.

3. Coordination and integration

Australia's health system is siloed and fragmented, leading to service gaps, duplication, and wasted resources. It needs improved coordination and integration to address these inefficiencies, and importantly, to better meet the needs of people with chronic and complex health conditions. Evidence demonstrates that effective service coordination and integration leads to increased service efficiency, better patient experience, and improved population health outcomes[20]. Care

[20] Primary Health Care Research and Information Service (PHCRIS), 2013. Towards integrated primary health care.

coordination refers to the linking up of existing health (and other) services to create a seamless patient journey through the health system. Service integration is a more involved process, where a team of different health providers will often share in such measures as objectives, responsibilities, accountability, key performance indicators, and in some cases funding. Coordination and integration can be applied in different ways and at different levels within and across the health system for example:

- Horizontal/micro: e.g. general practitioner, nurse, physio, psychologist, diabetes educator etc.
- Horizontal/macro (cross-sectoral): e.g. general practice, community health, refugee health, drug and alcohol service, housing, employment, community support services etc.
- Vertical: e.g. primary, secondary, and tertiary care

Service coordination and integration have an important role to play in Australia's health system because of their potential to reduce waste and improve health outcomes. As such, their realisation has been a strong focus of recent Australian health reform efforts. They have become a particular priority because of the need to link up a diverse range of multi-disciplinary services to prevent and manage chronic and complex conditions.

3.1 Barriers

3.1.1 Lack of acknowledgement and support for the role of nurses and midwives

An overarching barrier to service coordination and integration is the lack of acknowledgement and support for nurses and midwives as leaders and key players in the delivery and coordination of multi-disciplinary care. As is discussed under the Prevention, Health Promotion, and Early Intervention section of this submission, nurses and midwives have the skills and capacity to play greater roles in service coordination and integration than they currently are. If supported with the correct policy levers, such as appropriate funding, autonomy, and leadership recognition, nurses and midwives would further lead on coordinating and integrating health and social care services, especially for people with chronic and complex conditions.

3.1.2 Funding models

Health care funding arrangements are a significant barrier to realising better care coordination and integration. The funding split between Commonwealth and state and territory governments, in particular, creates unnecessary restrictions, disincentives, and red-tape for providers. Each source of funding has its own objectives, scope, limitations, and reporting requirements, which are often incompatible and conflicting. The prescriptions attached to different sources of funding often force a rigid and siloed nature on a health service which impedes them from being effectively linked-up. Arrangements of this nature make wide-spread coordination and integration very difficult across all levels.

Even in cases where there is only one source of funding, there are still structural barriers that stymie coordination and integration. The submission previously discussed how MBS fee-for-service funding discourages coordinated, multidisciplinary care in general practice because it rewards one-on-one, episodic care between the general practitioner and patient. Further to this, fee-for-service fails to effectively support general practitioners to collaborate with other team members, such as the nurse, dietician, psychologist, or podiatrist. The current MBS funding arrangement works in contradiction to what is known to promote integration; that is, common objectives, responsibilities, accountability, key performance indicators, and resources.

3.1.3 E-Health

Insufficiently developed eHealth infrastructure, and a lack of support for using it, is another impediment to service coordination and integration. Effective communication between providers is essential to a seamless patient journey, as well as for ensuring high-quality care and service efficiencies – such as by reducing service duplication. There has been much investment and effort in building Australia's eHealth infrastructure in recent years, such as through the Personally Controlled Electronic Health Record (PCEHR) and Secure Messaging. However, much work needs to be done before the PCEHR reaches a level conducive to effective inter-professional collaboration. One weakness in the PCEHR development process to date is its focus on supporting doctors only, leaving other team members such as nurses and allied health professionals without an opportunity to become involved. The PCEHR in its current form fails to support care coordination and integration amongst the full complement of health care professionals, which is essential if its benefits are to be realised.

3.1.4 Inter-professional understanding

Some health professionals lack knowledge and appreciation of the various professional groups' skills sets. As a result, many health professionals are unaware of what other professions can offer in terms of care and treatment options. This lack of appreciation can lead to cultural tensions between professions, further impeding effective service coordination and integration. This leads to patients not receiving treatment from the health professional with the skills set that best matches their needs. This leaves patients sometimes missing out on services they need, or otherwise having to navigate the complex health system on their own.

3.2 The nursing and midwifery professions' roles in coordination and integration

Nurses and midwives already play a significant role in care coordination and integration. The breadth and applicability of their skills means they work comfortably across different disciplines and sectors, connecting services to create seamless, consumer-centred care pathways. This role extends across all levels of the health system. Nurses and midwives liaise and collaborate with general practitioners, medical specialists, allied health providers, community pharmacists, as well as social and welfare services, among others. If given the mandate and autonomy to lead on care coordination, nurses and midwives can provide patients with care that reduces the risk of them falling through service

gaps. Care coordination will also contribute to reducing the inefficiency and duplication associated with service fragmentation by linking-up service sectors that tend to be poorly connected, such as aged care and general practice.

3.3 Policy enablers

Replacing the incumbent siloed funding models, created by different levels of government, with a clear line of funding that has consistent objectives, scope, and reporting requirements, is essential to realising a more coordinated and integrated health system. Such an arrangement would improve the efficiency of nurses and midwives who already work across health care sectors. Nurses and midwives in various outreach, consultancy and community roles currently link the various service sectors providing services to their patients. If policy levers are put in place to give nurses and midwives a stronger mandate, they could strengthen their contribution to care coordination. Governance arrangements that more closely integrate sectors and describe nurses' and midwives' role in the coordination of care across sectors are likely to be effective policy enablers.

Government must continue to invest in the development and roll-out of eHealth infrastructure. Support to adopt and use eHealth must be extended beyond doctors to health professionals such as nurses, midwives and allied health professionals. The development should take account of the many providers who play a critical role in the care pathway of patients. To exclude these groups of health professionals from the eHealth program disrupts the realisation of better coordination and integration for patients.

Greater communication and education about the contribution different health providers can make to health care overall should also be attempted. Policy levers that support professional development in inter-professional settings may encourage a breakdown of professional silos. Policies could target education providers to encourage them to develop and deliver inter-professional education where the course content lends itself to such delivery.

4. Workforce planning

Australia's ageing population and rising chronic disease rates will continue to increase demand for health services. However, Australia is unlikely to have the capacity to meet this demand without comprehensive, strategic health workforce planning now. By 2060 the number of Australians aged 75 years and over is expected to rise by four million, to 14.4% of the population. As the demographic shifts to an older population, the labour market will contract as people move into retirement or reduce their working hours. The Productivity Commission predicts that Australia's labour participation rates will decline from 65% to 60% between now and 2060. Overall labour supply per capita is also expected to decrease by 5% over the same period[21].

[21] Productivity Commission, 2013. An Ageing Australia: Preparing for the Future.

Nursing workforce research forecasts a significant shortfall in nurse supply by 2025[22], well before 2060 when the overall labour supply per capita is forecast to contract significantly. Midwife workforce predictions are currently unknown. This situation represents two highly significant problems for governments. Firstly, lack of workforce supply will negatively affect access to health care and likely contribute to poorer population health outcomes. Secondly, a tighter labour market for health care professionals is likely to put upward pressure on wages, causing budgetary pressures. For these reasons, nurse workforce planning and support now is especially critical to mitigate against the predicted shortfalls.

4.1 Barriers

A suitable agency should be tasked with providing the strong leadership in health workforce research and policy that is needed to address the significant risks associated with the predicted workforce shortages.

This concern about future health workforce supply is exacerbated when considering the current lack of workforce data, and the inadequacy of any incumbent future workforce planning strategy and policy. Problems associated with workforce shortages are already being observed, with shortages for example in the specialist mental health nurse workforce, being met by generalist nurses. Generalist nurses usually do not have the level of expertise to deliver the specialist mental health care required placing both the nurse and patient at great risk.

One factor underpinning this issue is the scant support that policy makers have given to the transitioning of nurses and midwives across different geographical locations and specialisation areas – into areas of greater need. The flexibility that nurses and midwives have to do this has the potential to improve health workforce retention, increase the system's productivity, and better meet the needs of a changing population. Transition supports for new nursing and midwifery graduates may help in reducing entry-level attrition rates by assisting them to become more comfortable in their new role. It would also help keep practicing nurses and midwives in the workforce by providing them with new opportunities and challenges.

4.2 Policy enablers

4.2.1 The general approach to nursing and midwifery workforce planning

Health workforce planning must address two broad issues:

- how to retain nurses and midwives in the workforce; and
- how to increase nurses' and midwives' productivity without decreasing the quality of care.

Further issues requiring attention relate to specific parts of the nursing workforce, such as:

[22] Health Workforce Australia. Health Workforce 2025.

- The need to enhance the number of nurses educated in primary health care to meet the greater demand that will be placed on this sector.
- The need to educate more nurses and midwives in Aboriginal and Torres Strait Islander cultural safety.
- The need to increase the number of mental health nurses to meet demand. This needs to involve reducing the stigma associated with mental health, and better managing incidents of violence and aggression associated with this role.
- The need to develop models of maternity care in rural and remote workplaces that enables the employment of direct-entry midwives.

4.2.2 A national, systematic approach to planning and innovation

An agency must take strong, visible health workforce leadership, which will include coordinating research on how health care settings can more innovatively meet future care demands. Particular attention should be paid to how the productivity of the nursing and midwifery workforce can be enhanced without risking care quality.

A national workforce plan for nurses in primary health care should be developed which identifies strategies for increasing the number of nurses with skills and experience appropriate for the delivery of primary health care services. Strategies must include the establishment of formal education pathways into general practice and other primary health care services and settings. The plan also needs to consider the balance between specialist skills (e.g. mental health, diabetes education) and generalist skills, which are highly necessary in the nursing workforce. Further, attention should be paid to the fact that the number of general practitioners in the workforce has remained stagnant over the last decade, with 41% being older than 55 years, suggesting a future shortage of general practitioners[23]. Consideration should therefore be given to the services that can be provided by nurses in general practice that do not require the attention of a medical doctor. This would help compensate for the expected general practice shortfall, as well as add to greater service access and efficiency, as has been discussed throughout this submission.

A national workforce plan for the specialist mental health workforce requires strategic responses that deal with the stigma of mental health, which currently affects recruitment of nurses into this specialty. Further, mental health nursing requires a systematic investigation of the effect that the policy environment has on mental health nurses' capacity to work therapeutically with consumers. Mental health nurses often lack job satisfaction because they have to implement policies and procedures that arise from the health system's risk adverse culture. These policies constrain their capacity to work therapeutically with consumers to support their recovery. The stressful nature of mental health nursing further reduces nurse retention in the profession. The national workforce plan needs to investigate how education providers can better promote mental health nursing as an interesting and challenging career choice for nurses.

[23] Australian Doctor (2014). 'Specialist numbers grow almost 20%', 10 September 2014

4.2.3 Utilising the full scope of practice

Providing legislative and workforce policy settings that enable nurses and midwives to work across their full scope of practice is critical to both attracting and retaining an adequate workforce, and the health system's productivity. Like all health care professionals, nurses and midwives like their work to be challenging and thrive on applying their skills to full effect.

4.2.4 Investing in and promoting nurse leadership programs

Initiatives are required that increase nursing and midwifery services' productivity, support service development and innovation and improve job satisfaction and promote staff retention. Improved leadership of practising nurses and midwifes has the potential to significantly contribute to these outcomes. National and international evidence consistently shows that nurse leadership at the clinical level is linked to better patient outcomes and improved job satisfaction and retention in the workforce. However, to date the development of nurse and midwifery managers' leadership capabilities has received little consideration in spite of nurses' and midwifes' work being a major input in the production of care.

Because the two professions are big contributors to care production, nursing and midwifery based service development and innovation promises a significant impact on service quality, productivity and staff retention. A coordinated national approach to developing and promoting bespoke leadership programs for nurses and midwives will make an important contribution towards achieving optimal use of nursing and midwifery resources. Nurse leadership programs should include structured education, mentoring, exposure to best practice leadership, critical appraisal of leadership methodologies and the contextualisation of these methodologies to health care settings.

4.2.5 Developing nursing and midwifery transition support programs

Formalised transition support programs to assist newly registered nurses and midwives transition into clinical practice, as well as to assist those at later stages of their career to move across clinical areas of practice and settings, would contribute to workforce retention and productivity by improving flexibility and increasing the opportunity for new challenges. Transition supports would include programs across the whole health care sector such as those that would assist nurses and midwives to move from hospitals to rural or remote practice, or nurses from generalist nursing to mental health nursing.