australian nursing federation

Parliament of Australia
House of Representatives
Standing Committee on Health and Ageing
Inquiry into Health Funding

SUBMISSION
of the
Australian Nursing Federation

The ANF urges the Committee to take the broadest possible view in relation to issue of health funding. The allocation of health funding must follow the formulation of robust health and social policy - NOT drive it! The underpinning principle should be the quest for quality and safety in health care. This is an opportunity to develop robust health policy for the benefit of all Australians and their health into the future with the assistance of health consumers and the health professionals that are essential to the system.

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1. The Australian Nursing Federation

1.1 The Australian Nursing Federation (ANF) is the national union for nurses in Australia with branches in each state and territory. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing in Australia.

1.2 The ANF's 145,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.

1.3 The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veterans affairs, education, training, occupational health and safety, industrial relations, immigration and law reform.

2. General Comments

2.1 The ANF has a critical interest in the current Inquiry into health funding because of the central role nurses play in the delivery of health services. Nurses comprise almost 50% of the health workforce. The manner in which health services are funded and structured has a major impact on nurses and their capacity to delivery quality nursing care.

2.2 In the course of the Inquiry, the ANF submits that all aspects of health service delivery need to be considered – including structural issues; resource issues; workforce issues; and education issues. The health system should be seen as an integrated whole across the continuum of care - including care in the community, acute care, rehabilitative care, aged care and palliative care - with multiple entry and exit points.

2.3 The ANF supports the continuation and enhancement of a public health system for all Australians that is universal, free at point of delivery and funded through taxation, with a private health sector that is complementary to the public sector.

2.4 Because nurses want to be able to provide high quality nursing care, the ANF wants health and aged care systems that:

- are first and foremost centred upon the health needs of the Australian people;
- involve those people actively in decision making in health policy and resource allocation;
- are properly funded, universal and well coordinated;
- truly value people and the nurses who care for them; and
- support a skilled and sustainable nursing workforce (Iliffe, 2004).

2.5 The ANF is of the view that these goals are currently not being met across the Australian health system. Examples include:

- Waiting times in emergency departments and for elective surgery are still unacceptably high.
- Shorter stays results in a greater turnover of people with more complex care needs. The effect on nurses is increased workloads, no downtime, greater stress with admissions and discharges, let alone more complex care requiring greater alertness and vigilance. Figures from the AIHW clearly demonstrate the increased workload for nurses with higher levels of patient separations and days per full time equivalent nurse.
- Nurses are frequently being required to provide care with inadequate material resources and in situations where, it could be argued, they are in danger of breaching their own professional standards and duty of care. For example, people waiting or being treated on trolleys in corridors because there are no available beds. This is not the kind of environment where nurses are happy to provide care, yet they often have no other alternative. This leads to low staff morale and more nurses leaving the system.
- The discharge of people requiring more complex care has put a strain on community resources which they are unable to meet. This is resulting in poorer health outcomes for people and placing a greater burden on families to provide the care (eg early postnatal discharge, failure to establish breast feeding). The

issue is not the desirability or otherwise of early discharge, but the inadequacy of community resources for appropriate follow up. Nurses are often placed in a situation where ethically they do not want to discharge people because they inow they will not be able to access the community care they need, however pressure is being placed on them to discharge as the bed is required for a more acute admission.

- Staffing levels are reduced, ostensibly to save costs, which increases workloads and gives rise to increased rates of adverse outcomes, occupational injury (stress, needle stick injury, back injury), sick leave and staff turnover. Increasing numbers of nurses are leaving the profession or choosing to work part time or casual in an effort to control their workloads. This puts an even greater strain on those nurses that remain as full time workers as they are constantly orienting new staff unfamiliar with the environment or picking up workloads for new staff who are unable to perform high level functions.

2.6 Australians are increasingly becoming aware that their health care system is unreliable at times, and at other times, dysfunctional. Public hospitals have major problems because of ever-increasing demand, lack of funding, and shortages of appropriately skilled health professionals. The essential continuum of care that should link primary, community, aged care and hospital services is made all but impossible because of the jurisdictional inefficiencies associated with the poor relationships between the Australian Government and the State and Territory Governments. Effects include:

- Elective surgery for people in need is rationed;
- The predicted and serious future nursing workforce shortage, because we are not educating sufficient nurses to replace those who will be retiring from the sector over the next 10-15 years, will impact directly on the health and wellbeing of the Australian community yet nursing is not 'owned' or respected at the Australian Government level;
- General practitioners are undertaking little after hours work;
- Hospital emergency departments are becoming defacto primary care centres placing enormous pressure on those services;
- Specialist medical and allied health providers' fees make it increasingly difficult for a large number of Australians to benefit from their care;

- Universal health insurance is covering less of an individual's health costs;
- The non-inclusion of some drugs in the Pharmaceutical Benefits Scheme (eg some palliative care pain relief medications are available in hospital but not for use at home);
- Lack of coordination of care for people with chronic and multiple health requirements across primary, acute, rehabilitative, disability and aged care services;
- Inadequate access to dental care is significantly impairing the overall health of people unable to afford private dental services;
- The cost of private health insurance is increasing, falling out of the range of many in the community to afford; and
- Personal finances and capacity to pay are increasingly becoming a major determinant of health care and health outcomes (Consumers' Health Forum of Australia, 2004; Dwyer, 2004).

2.7 The Australian Health Care Reform Alliance, an Alliance of 28 health related organisations, including the ANF, was formed when it became apparent that the Australian Health Care Agreements 2003-2008 would not include the reform agenda being advocated by health professionals and consumers. The initial negotiations suggested that a reform agenda to close the gaps, eliminate cost shifting, and introduce greater equity and accountability, would be an integral part of the new Agreements.

2.8 The Alliance hosted a Summit in Canberra 17-19 August 2003 where invited speakers and participants worked together to develop policy initiatives to improve and add value to our health system. The Summit called on the Australian Government and the State and Territory Governments to defer signing the Agreements or to sign interim Agreements so that the health reform agenda could be incorporated (Iliffe, 2003). Unfortunately this did not occur.

2.9 The Alliance developed the following principles, supported by the ANF, in advocating for reform of the Australian health system:

AUSTRALIAN HEALTH CARE REFORM ALLIANCE PRINCIPLES:

1. The aims of Australia's health strategy should be health and social justice outcomes; acknowledging the economic contribution of a healthy population and a viable health industry.

2. Our national health strategy should provide clear principles on which resource allocation is based, and against which allocations can be judged.

3. A financially viable national health strategy will require significant innovation. This includes new policies, financing mechanisms, taxation arrangements, health service networking, government administrative processes, and more effective collaboration.

4. Developing this strategy requires proper evaluation of the full spectrum of health service delivery models and options, and the full spectrum of health financing approaches:
    a. This evaluation needs to consider fully the contribution which health care makes to economic performance and other societal values.
    b. The heart of health care is the health workforce. There must be sufficient economic incentives and support so that skilled people are attracted to deliver services for all sectors of society.
    c. The strategy needs to be based on a sophisticated understanding of how health needs will evolve with a changing population and changing policy contexts, and the health, social and economic impacts of different types of health care strategy.

5. Prevention needs to be valued, understanding that it is more likely to shift costs through time than reduce them outright.

6. A key aim of a national health strategy should be social inclusiveness, not minimal safety nets.

7. Social justice is central to a national health strategy, in particular with regard to Aboriginal and Torres Strait Islander peoples.

8. The needs of regional and disadvantaged communities should be carefully considered as part of such a strategy.

9. Any such strategy has to tackle the problem of institutional complexity and the transaction costs of administration. This includes better specification of federal/state and public/private roles, and the removal of silos that inhibit efficiency.

10. A sustainable health care system has to be fair and efficient, and deliver health outcomes that the community wants, and will value.

Creating that strategy requires a process that is open, which takes fully into account the knowledge and needs of the people who deliver health care services, and the people who use them. Achieving a process that ensures this is an initial objective of the Alliance (Australian Health Care Reform Alliance, 2004).

2.10 The Australian Health Care Agreements are only one example of political point scoring at the expense of improvements in health services and health outcomes. The agreements were signed and an opportunity lost to introduce essential reforms that clinicians all over Australia were calling for (Iliffe, 2004).

2.11 Neither the broader community nor clinicians are having effective input into what changes are funded and implemented. Clinical decisions are being made by politicians - not for the good of the community, but for their own political advantage, either to gain political points or to minimise political damage.

2.12 It is very discouraging to see health care decisions being made for purely political reasons. The additions made to the Medicare Plus package in 2004 to ensure its passage through the Senate are an example of politicians bargaining with the health of the Australian community to gain a political advantage (Iliffe, 2004). The Medicare Plus package granted a $5.00 increase in the schedule fee to doctors if they bulk billed children, people on pensions or people with health care cards. In designated rural and remote areas, the increase in the schedule fee is $7.50.

2.13 However the Tasmanian senators managed to have the whole of Tasmania, including the city of Hobart, deemed equivalent to rural and remote areas, allowing doctors in Tasmania to receive the $7.50 rebate if they bulk billed children, people on pensions or people with health care cards regardless of whether they live in a city, a rural town, or a remote location (Iliffe, 2004).

2.14 The Medicare Plus package also provided additional money to progress health information technology initiatives. While important for the whole of Australia, the money only went to South Australia and Tasmania. Three of the independent Senators whose vote was essential for passage of the legislation came from those states (Iliffe, 2004). To gain political advantage, in both cases the important principle of equity was compromised.

2.15 The failure to broker any real reforms in the health system under the Australian Health Care Agreements has a major impact on nursing and hence the community who require nursing care. The latest report from the Australian Institute of Health

and Welfare shows a continuing decrease in the number of nurses per 100,000 population - from 1074 in 1993 to 1024 in 2001 (Australian Institute of Health and Welfare, 2002).

2.16 The percentage of nurses over the age of 45 continues to increase (17.5% in 1986; 30.3% in 1996; 37.3% in 1999; and 41.7% in 2001), while there has been no improvement in the percentage of nurses under the age of 35 (33.3% in 1995; and 24.7% in 2005). The allocation of additional undergraduate places for nurses in recent federal budgets will have little impact when over a third of nurses will be contemplating retirement within the next 10-15 years. In raw numbers, that equates to nearly 70,000 nurses! (Australian Institute of Health and Welfare, 2002).

2.17 This is why the ANF has been an active partner in the Australian Health Care Reform Alliance. Nurses care about what is happening to our health system and our health services. Nurses want sufficient funding for the whole system - not just nursing - to be able to provide appropriate care when it is needed; sufficient staff to be able to provide it; with workloads that allow them to provide quality care and maintain a reasonable family and work balance. Nurses want health funding to be spent only on health and for governments as well as health providers to be accountable and transparent in the way it is spent (Iliffe, 2003).

2.18 Health consumers have also been vocal in their views about health funding in Australia. Both the Consumers' Health Form of Australia (CHF) and the Health Issues Centre in Victoria have been active in canvassing consumer opinion and developing consumer policy in this area. The CHF says: *Consumers do not see health care in terms of funding structures and political jurisdictions. Each health consumer has specific health needs and costs and seeks a health sector capable of meeting these needs and improving their particular health outcomes.* (Consumers' Health Forum of Australia, 2004) Usefully, the CHF has developed a set of criteria for assessing health funding reform which should assist the Committee in its deliberations.

2.19 These criteria are listed below:

CONSUMER CRITERIA FOR ASSESSING HEALTH FINANCING REFORM:

- **Universality** – Does the policy recognise health care as a basic human right and build upon the universal basis of Medicare?
- **Equity of access and outcomes** – Does the policy promote equitable access to health services, and encourage equitable outcomes for all population groups in Australia?
- **Quality** – Does the policy promote quality of care and focus on health outcomes as defined by consumers?
- **Transparency** – Does the policy provide for information and accountability to consumers in terms of both cost and quality?
- **Affordability** – Does the policy ensure the affordability of health services to consumers and the community and minimise the incidence of uncapped consumer co-payments?
- **Directness** – Does the policy maximise the funding which goes directly to health service provision, and minimise the funding which is channelled to indirect sources such as public and private administration?
- **Value for money (technical efficiency)** – Is the policy efficient and does it avoid "false" economies, such as cost shifting, unintended consequences and flow on effects?
- **Best use of money (allocative efficiency)** – Does the policy encourage the allocation or reallocation of resources in ways which are likely to bring about equitable and optimal health outcomes?
- **Health creation** – Will the policy contribute to the creation of a healthier community, rather than merely treating existing illness and/or injury?
- **Consumer participation** – Have consumers been actively involved in the development of this policy? Will consumers be included as partners in implementation, monitoring and evaluation?

(Consumers' Health Forum of Australia, 2004)

2.20 The ANF is strongly of the view that the health reform agenda is broader than just hospital throughput. The most recent review of the Australian Health Care Agreements did provide an opportunity to acknowledge and embrace this - to set agreed targets for health outcomes; to coordinate care across the hospital/residential/community and public/private interface; to establish objective, measurable and published performance criteria; for governments at all levels to collaborate to close the gaps and eliminate cost shifting; and for us all -

governments, providers, workers and consumers, to work together to provide the best care possible to our community (Iliffe, 2003). That was an opportunity lost.

2.21 The remainder of this submission will make some brief comments in relation to the specific terms of reference of the Committee. However the ANF urges the Committee to take the broadest possible view when looking at the issue of health funding. The allocation of health funding must follow the formulation of robust health and social policy - NOT drive it! The underpinning principle should be the quest for quality and safety of health care. This is an opportunity to develop robust health policy for the benefit of all Australians and their health into the future with the assistance of health consumers and the health professionals who are essential to the system.

3. Roles and responsibilities of the different levels of government (including local government) for health and related services

3.1 Little has changed since 1999 when Duckett said:

> *Government responsibility for health and community services in Australia is shared between the Commonwealth and the states. Unfortunately, this sharing is not done in a consistent and coherent manner, and it is difficult to develop comprehensive national policies in this area. The state responsibility for hospital services, the Commonwealth responsibility for medical services, the joint responsibility for home and community care projects, and the divided responsibility for disability services, render coherent policy-making at the state level almost impossible.* (Duckett, 1999)

3.2 John Menadue in his critique of the health system in Australia in 2004 says:

> *The structure of the workforce is more appropriate to the needs of the 19th century than the 21st century. It is archaic and incoherent. As put to me by a senior clinician in NSW, we have boxes everywhere, junior doctors, clinicians, nurses, allied health, managers, colleges and universities, but there is not a thesis or a plan that draws it all together. Training and work are in separate*

compartments. Teamwork is not promoted. Work demarcations abound. Health is rife with restrictive work practices and denial of career prospects, particularly for nurses, whether it is in the community or hospitals. Many senior nurses are more skilled and experienced than most junior doctors and many registrars. Because of the opposition by obstetricians, less than 10 per cent of normal births in Australia are managed by midwives. In the Netherlands it is over 70 per cent and in the UK over half. Many more leave nursing for management or academia because of a lack of career prospects and financial reward. The medical colleges protect their own interests in the name of 'quality' (Menadue, 2004).

3.3 The ANF is strongly of the view that there are considerable disincentives to achieving the goals of consumers, the ANF and the Australian Health Care Reform Alliance with the current dysfunctional relationships that exist between the different levels of government in Australia. Lack of trust, overt cost shifting and little cooperation and coordination in cogent policy making, funding arrangements, service planning and service delivery are features of the current health system in Australia.

3.4 There are numerous examples of cost shifting between levels of Government. Cost shifting occurs all along the line. Not only is there cost shifting between different levels of government, but also cost shifting to consumers eg prescriptions not medicines being provided on discharge and consumers having to provide their own dressings, appliances, aids etc. Community services cost shift to Home and Community Care services, who charge for their services or cost shift to volunteers or family carers. Cost shifting occurs in hospital emergency departments and out patient departments when people are referred to their general practitioners for care or for a referral to a specialist medical practitioner instead of being treated on site. Consumers are required to have their pre hospital admission workups done by private pathology or radiology services. In rural areas, there is often no salaried doctor attached to the health services, so the system must rely on general practitioners or visiting medical specialists. There is no incentive for State and Territory health services to employ salaried doctors as this would incur a cost for

them. Practical and cost effective solutions to all of these issues are possible providing there is a will to do so.

3.5 The ANF does not support a situation where different levels of Government fund different areas of the health system. It is inefficient for the Australian Government to directly fund some health services (such as aged care and out of hospital medical care) while the State and Territory Governments fund other health services such as in patient and out patient hospital care. In saying that, the ANF does not consider that the State and Territory Governments should abrogate their responsibilities for providing and managing their health services. A far more efficient system would be for the Australian Government, through the Australian Health Care Agreements, to provide funding to the States and Territories for them to provide for all the health needs of their communities. This includes community care through the Home and Community Care program. The Australian Government would have a key role in setting the national health agenda and national health priorities, and setting standards and performance criteria for the States and Territories to meet in relation to health services provided. There is now sufficient data to determine an appropriate formula to adequately fund States and Territories to meet their population health needs.

1. Simplification of funding arrangements, and better definition of roles and responsibilities between the different levels of government, with particular emphasis on hospitals

4.1 There is no doubt that there are significant reforms to be made across the Australian health system. There is extraordinary willingness from the consumer and health professional groups to assist the Committee in this task. As the ANF has suggested above the reform of health funding must be driven by the reform of health policy and this will require cooperation and innovative thinking involving the key stakeholders such as the states and territories, health consumers and health professionals.

4.2 Political point scoring must be put aside and consumer interests and needs must be the paramount focus.

4.3 The complexity of the current system and lack of rationality in the roles and responsibilities of the three layers of government in Australia warrants attention, debate, innovation, commitment, effective reform and investment to be able to meet the challenges posed in the recent report: *Economic Implications of an Ageing Australia* (Productivity Commission, 2005).

4.4 The UK, the USA and Canada have all been reviewing their health policies over the past decade and there is much to be learnt from those jurisdictions – both positively and negatively. Other international references should be reviewed also for useful lessons.

4.5 One model is described by John Menadue who has the benefit of reviewing several State systems closely, as well as the Australian Government role in the Australia's health system:

> *It would be sensible for the Commonwealth to take over state hospitals, but that is an inadequate response. It would leave unresolved the lack of integration of health services between hospitals and other providers of health services. Any integration should include not only state hospitals, but other state health services such as disability, Aboriginal, mental health, dental, child and youth, domiciliary care, nursing and drug and alcohol services. They must all be included in the package or the present fragmentation will continue.*
>
> *A state handover of health services to the Commonwealth may be politically too difficult for some states. A practical and feasible alternative which is being canvassed, would be to establish a joint Commonwealth/State Health Commission in any state where the two governments could agree. I envisage that the joint commission, with shared governance, would be responsible for the funding and planning of all health services in a state. Consistent with an agreed plan, the commission would then buy health services from existing providers - Commonwealth, state, local, NGO and private.A political agreement between the Commonwealth and any state is essential. If this political agreement is achieved, I am confident that we would see a more cohesive and integrated health service, delivered much more efficiently. Once the benefit was clear in one state, probably a small state to begin with, I am sure other states would follow.I think this proposal is feasible and would have strong public support* (Menadue, 2004).

4.6 There are other models that deserve consideration. For example the Health Issues Centre in Victoria has recently produced an edition of Health Issues with a number of articles that demonstrate quite forcefully how health consumers can contribute to the debate with innovative and well thought through views (Health Issues Centre, 2005).

4.7 While the ANF has much to offer in the way of experience, understanding, ideas and effort, a formal submission process cannot achieve effective outcomes until robust community debate maps out a collective way forward. The ANF would welcome the opportunity to be part of that. This is not a time for quick fixes.

2. How and whether accountability to the Australian community for the quality and delivery of public hospitals (sic) and medical services can be improved

5.1 Few will dispute that the health and aged care systems have been traditionally provider focussed enterprises rather than consumer focussed. Hospitals and health services are organised for provider expediency NOT consumer convenience. Consumer stories of their tortured negotiation through a system of silos that represent the current structures in health services organised in specialties and professional groupings abound. Review of the annual reports from the state and territory health complaint watchdog agencies are one accessible source of such information.

5.2 Questions about the quality and safety of health care and the risks to health consumers has also come into sharp relief since the work done over the past decade. For example: the Professional Indemnity Review (Tito, 1992, 1994, 1995); the Quality in Australian Health Care Study (Wilson, Runciman, Gibberd, Hamilton, & Harrison, 1995) and equivalent studies in the USA (Brennan *et al*, 1991; Leape *et al*, 1991), New Zealand (Davis *et al*, 2002, 2003), the United Kingdom (Vincent, Neale, & Woloshynowych, 2001) and Canada (Baker, Norton, Flintoft, & *al*, 2004). This requires a real re-evaluation of health policy to ensure that all safeguards are

in place to minimise the risks and learn from previous errors and 'near misses', not tinkering around the edge of existing health policy.

5.3 The ANF notes that all the questions outlined in the funding criteria above from the Consumers Health Forum go to testing the accountability for the quality and safety of the health system. Active participation and involvement of Australian health consumers in all levels of health policy development, planning, monitoring and review is instrumental to diluting the powerful voice and diversity of interests (however well intentioned) that the current providers in the health system have in relation to the design and function of the system. The work of the Consumers Health Forum, the Health Issues Centre in Victoria, the federally funded Consumer Focus Collaboration and the Australian Council for Quality and Safety in Health Care provides important assistance in looking at ways to engage and listen to health consumers and enabling them to participate in these important functions of policy review and development.

5.4 Health consumers lament the lack of clear, informative and useful information available to them about the health system and health services that will assist them to make informed decisions. They have been at the forefront of a push to get better information systems and reporting happening in the health system. It is time that they ceased to be treated as mushrooms and high risk litigants and are actively engaged in developing a transparent system providing them with freely given information and more say about the health system they want.

3. Ensuring a strong private sector can be sustained into the future, based upon positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government

6.1 The ANF supports a viable private health care sector for those that wish to utilise it and can afford to. However, the public health care system should be available to all and not be set up to compete with the private health sector. There are models

where the relationship can be a cooperative one rather than a competitive one. The private health sector should be complementary to, not in competition with the public health sector.

6.2 It is the view of the ANF that the private hospital sector should be directly funded with a bed subsidy so that they can also provide care to public patients who are prepared to pay the additional cost for the convenience of a more certain admission date and their doctor of choice. People with private health insurance should be able to insure against these additional costs.

7. Innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover

7.1 The ANF does not support incentives to make private health insurance an attractive option. There is no logical reason why the private health insurance industry should be protected in a way that other insurers are not. The ANF strongly supports a universal health insurance system to enable equity of access to all necessary health services for all Australians. The most equitable way for people who can afford to do so to contribute more to the health system is through taxation ie increasing the Medicare levy. Private health insurance should be an optional extra. Private health insurers should be able to offer a wide range of services with the exception of those covered by Medicare, that is out of hospital medical costs and public hospital services, with minimal government interference or financial support.

7.2 The ANF is of the view that there is a vital need to review the usefulness of the private health insurance rebate, especially as it has not achieved any of its objectives, ie relieving pressure on the public hospital system, making private health more affordable or keeping the cost of private health services down. The private health insurance rebate represents a significant outlay of public money, yet it was not subject to any rigorous or transparent analysis that was made publicly available. Substantial shifts in health policy of this kind should go through a

rigorous and transparent policy process. There are too many examples of health policy decisions being made by politicians to achieve a political objective without a rigorous analysis of their long term effects. A classic example is the need for a recent change of policy on safety nets.

7.3 A review of the private health insurance rebate should be commissioned to fully consider whether the public benefits from the rebate outweigh public costs. Such a review should be conducted in a transparent manner with widespread public consultation. It should also consider potential alternative options. The review should include a comprehensive technical analysis of the economic and social impact of the policy and of potential alternative means of achieving the Government's objectives. Even if such a review found that the policy would yield a net public benefit, there is an obligation on Government (under National Competition Policy) to ensure that no alternative policy response would achieve the same objectives at a lower cost.

7.4 The rebate in essence funds private health insurance companies and not private hospitals. Ian McAuley argues cogently on this point and has done much work on the breakdown of the rebate dollar and how much goes on administration and how much ends up supporting the provision of private hospital services. He asserts that if public money is used to support the private system it should go directly to private hospitals as subsidies for offering services to patients, including public patients. This would certainly decrease public hospital waiting lists (McAuley, 2004). We need to support the private system in a manner that is complementary to the public system, not in direct competition.

8 Recommendations

8.1 That the Australian Government institute a process of community consultation in relation to reform of the Australian health system similar to the community consultation process that took place in Canada and the United Kingdom. The community consultation process should be extensive and wide ranging.

8.2 That in order to facilitate the community consultation, an Australian Health Reform Commission is established in the short term to oversee the process and make recommendations for properly planned and funded incremental reform of the health system over the next twenty years.

8.3 That any consideration of reform of the health sector include discussion with the education sector, as the education sector has responsibility for providing places for the education of the health workforce.

9 Conclusion

9.1 The ANF is committed to working with governments on behalf of nurses. But governments need to care for people – the people they provide services to and the people who provide those services – especially nurses.

9.2 To obtain the best health outcomes and contain health costs into the future, we need politicians who have the courage and vision to look at the system as a whole, listen to health consumers and health professionals as well as health administrators and make decisions on what is best for all of us.

9.3 The ANF wants to work with a government that is prepared to listen, take our issues seriously, resolve them, and deliver strong, efficient, quality health and aged care services.

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