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nursing federation

## Submission to the Australian Government on the Australian Health Care Agreements

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April 2008

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The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses, with branches in each State and Territory of Australia. The ANF is also the largest professional organisation in Australia, with a membership of 160,000 nurses, employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The ANF's core business is the industrial and professional representation of nurses and midwives and nursing and midwifery.

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

## 1. Introduction

1.1 It is the view of the ANF that the Australian Health Care Agreements (AHCAs) need considerable reform in both structure and content if they are to meet the needs of the Australian community into the future in being able to provide for individuals to have free access to public hospital services on the basis of clinical need. The policy framework for these agreements needs to be considerably strengthened and the reporting of outcomes considerably increased to improve the transparency and accountability of funding for Australian taxpayers.

1.2 In the short term, the Australian Health Care Agreements should be broadened to include the current federal and state/territory funding for community-based care, as well as public health measures funded under the Public Health Outcomes Funding Agreements (PHOFAs). This could assist in improving the coordination of care between the community and public health programs with the hospital sector, and provide for more integrated health services. It is recognised however that over time, in keeping with any recommendations from the National Health and Hospitals Reform Commission, the Australian Health Care Agreements may themselves be considerably reformed and alternative arrangements for the funding of hospitals developed in line with other long term reform of methods for funding and delivery of health services. Pressures for reform are considerable: demand for hospital services in Australia is growing at an exponential rate, and meeting this demand, or alternatively offsetting it through structural reform to focus expenditure and services on providing preventive care through better primary health care services, will be required if community health needs are to be met in the future.

## 2. Indexation

2.1 The federal government's contribution to the Australian Health Care Agreements has declined in recent years. It is recommended that there be a re-introduction of a 50: 50 ratio in federal: state/territory contributions, and an increase in the indexation formula to reflect the increasing cost of providing health care.

### 3. Accountability and transparency of expenditure and service delivery

- 3.1 There is an urgent need to improve accountability and transparency associated with expenditure and delivery of services under these agreements. Additional indicators that are nationally consistent need to be developed to improve monitoring of the performance of hospitals, and evaluations of performance must be made public.
- 3.2 There are currently little in the AHCA's to evaluate hospital performance in the areas of equitable access, safety and quality and effectiveness of services.

### 4. Measuring performance

- 4.1 Performance indicators should be developed to demonstrate improvements in equity, safety and quality, and effectiveness of services by monitoring:
- access to services (beyond the crude measure of waiting times);
  - access according to geography (to demonstrate variability between metropolitan, regional and remote and reduce disparities in access);
  - equitable and nationally consistent patient assisted travel schemes;
  - delays in referrals;
  - cost effectiveness of services;
  - avoidable admissions (to demonstrate how effectively care is being provided or able to be accessed in the community);
  - safety and quality indicators (e.g. mortality rate by institution or aggregated health provider/s), occurrence of adverse events (e.g. hospital acquired infection, failure to rescue; incidence of decubitus ulcers; use of restraints; surgical wound infections; hospital acquired septicaemia; hospital acquired pneumonia; patient falls; and postoperative pulmonary embolus or deep vein thrombosis);
  - compliance with clinical guidelines (to demonstrate the delivery of effective, evidence based care);
  - emergency readmission rates (to demonstrate where the incentive for throughput may have overshadowed clinical appropriateness).
- 4.2 Additional indicators should be developed to demonstrate the effectiveness and appropriateness of care for specific populations, such as:
- specific indicators for evaluating health outcomes of Indigenous people;
  - the provision of culturally appropriate care;
  - access to primary health care services for Indigenous populations;
  - specific indicators for access to mental health services; and
  - specific indicators for access to dental and oral health services.

- 4.3 Consideration should be given to the development of indicators regarding access to a range of services, including the availability of appropriate health professionals, such as:
- numbers of nurses or midwives available per person; and per service.
  - access to community care by number of services per person; by type of health professional; by remoteness of residence; and socioeconomic status;
  - access to mental health services; and
  - access to public oral and dental health services.
- 4.4 The effect of the composition and adequacy of the nursing and midwifery workforce and nurses' and midwives' work environment (and that of other health professionals) on the safety and quality of care has received far too little attention to date in hospital performance evaluation. The framework for a workforce reporting database should be included in the AHCA's and indicators developed to demonstrate workforce capacity. There is clear evidence that factors such as staffing, workload, and skill mix all impact on the ability of health professionals to deliver safe, quality care. Increasing mortality and morbidity, extended length of stay, increased incidence of pressure sores and hospital acquired infections and patient falls are associated strongly with inadequate nurse staffing, excessive nursing workloads and inadequate nursing skill mix. It must therefore be a priority in demonstrating hospital performance that indicators be developed to demonstrate:
- staffing (including numbers of nurses and midwives per service provider);
  - workload (including patient "churn");
  - skill mix (proportion of assistants in nursing, enrolled nurses and registered nurses);
  - education (proportion of nursing staff with undergraduate and post graduate qualifications);
  - staff satisfaction;
  - staff turnover (to demonstrate the level to which staffing concerns are being addressed).
- 4.5 Occupational health and safety (OHS) is a critical component of nurse recruitment and retention, therefore compliance with OHS legislation, including policies and procedures to prevent and manage occupational health and safety hazards and risks associated with nursing work should also be demonstrated. This should include appropriate occupational health and safety benchmarks, such as:
- workplace injuries (risks to staff); and
  - compliance with occupational health and safety legislation.

- 4.6 Given the important role of public hospitals as teaching and learning environments, specific provision should be made to ensure that appropriate resources are available for clinical learning. The need to increase the system's capacity to support clinical learning is becoming especially urgent. Addressing this systemic capacity deficit is crucial to addressing overall workforce shortages. Performance indicators are necessary to measure this.
- 4.7 Consideration should also be given to the development of additional nursing-specific indicators to demonstrate the links between nursing interventions and patient outcomes.
- 4.8 An important principle of health care must be that it is patient centred, and reflect a commitment to health care as a human right. The Australian Health Care Agreements should contain a preamble to reflect this fundamental principle and express the commitment to the provision of universal publicly funded services available to people within a clinically appropriate period, on the basis of need, not their ability to pay. The development of an indicator regarding the availability and implementation of a charter of rights for health care consumers should be considered as an indicator.
- 4.9 A patient focussed system should mean that the experience of patients or consumers in the health system is evaluated and that information is used to improve care. Therefore it is important that indicators be developed to evaluate, record, and report on:
- patient satisfaction/consumer experiences of care.
- 4.10 The delivery of coordinated, integrated care relies on the effective sharing of information between health professionals and health care providers. To ensure this occurs across institutions and jurisdictions, performance indicators should be developed to demonstrate:
- the implementation of a nationally consistent electronic health record; and
  - the development of nationally consistent data, terminology and definitions (to assist comparison).
- 4.11 The demonstration of responsible environmental management should be part of the performance assessment of public hospitals to assure the public that expenditure is not being used in ways that exacerbates the impact of the climate change on human health. Given the considerable energy usage of this sector and the large volumes of waste produced in the delivery of hospital and health care services, it is incumbent upon the sector to accept responsibility for minimising waste and improving energy efficiency to reduce contributions to an exacerbation of climate change and concurrent detrimental effects on human health. The performance of hospitals and health care settings funded under the AHCA's should therefore be monitored by:
- conducting and reporting the results of energy audits to assess environmental footprint with respect to greenhouse gas emissions; and
  - conducting and reporting waste audits.

## 5. Staffing and industrial arrangements

- 5.1 A fundamental reform of AHCA's should be to establish reporting and performance benchmarks in respect to staffing and industrial standards between health services and their employees.
- 5.2 The delivery of health services is dependent on a wide range of people including doctors, specialists, nurses, midwives, allied health professionals and ancillary staff. Nursing constitutes over 50% of the health workforce.
- 5.3 Labour and related costs may constitute up to 70% of the overall costs of operating a health service.
- 5.4 There is overwhelming evidence that supply of nurses and midwives and other allied health professions is an increasingly significant factor in the ability to provide adequate levels of health services. There is a longstanding shortage of nurses and midwives both within Australia and internationally and it is accepted by most commentators this is a structural and entrenched shortage rather than one arising from cyclical factors impacting on the supply of labour. We do know that in Australia however, the shortage of nurses is in fact a shortage of nurses willing to work in the health system. Over 30,000 nurses are registered but not working, and an innumerate number of nurses have allowed their registration to lapse.
- 5.5 The decentralisation of industrial relations in Australia over the past 10 years (primarily through agreement making) has increased competition between health agencies to recruit and retain adequate levels of nursing staff. This has led to an increase in the mobility of nurses and midwives moving from one health service to another.
- 5.6 The increased mobility arising from industrial considerations is often a waste of health resources and ultimately has an adverse affect on the continuity of nursing care.
- 5.7 There is nothing in the current agreements that requires health services to meet minimum standards in staffing and industrial practices.
- 5.8 Poor industrial conditions are one of the main reasons for nurses and midwives leaving the profession altogether.
- 5.9 The new AHCA's should introduce a reporting requirement that health services detail their staffing and industrial employment arrangements and meet minimum benchmarks, particularly retention.
- 5.10 Health services should also be required to operate within established industrial frameworks including a requirement to collectively bargain, to recognise the role of unions within the workplace and to embrace industrial outcomes that will enhance recruitment and retention outcomes.

## 6. Long term reform

- 6.1 While it is recognised the timeframe for the next round of Australian Health Care Agreements will not allow for significant reform, the ANF would like to make the following remarks with respect to long term reform of these and other health care funding arrangements:
- 6.2 The future sustainability of the health sector depends on considerable reform. The inflationary pressures are huge, the demands on the system increasing, and the workforce under increasing pressure amidst global workforce shortages. Continuing to fund our hospitals separately from other health services diminishes the opportunities for coordinated care, reduces the capacity of the system to integrate different health services and increases the risk of costs shifting and duplication of services.
- 6.3 Improving access to, and improving the quality of, primary health care delivered outside of hospitals to prevent illness and promote healthy communities is the only way we can reduce long term demand for our very expensive acute health care services and improve population health outcomes.
- 6.4 A reformed system must consider the needs of the patient and design the system accordingly to meet those needs. This will require a system that provides for a coordinated patient journey throughout the health system, where records are shared between providers and there is no financial incentive to cost shift between funders or providers.
- 6.5 This system could be facilitated by the adoption of a mechanism for funding similar to that of public hospitals under the Australian Health Care Agreements to encompass funding for all health care i.e. all public funds currently provided for hospital services (AHCAS), community care, mental health, primary care (MBS), aged care, pharmaceuticals (PBS) and public health measures (PHOFAs) etc. A pooled source of funds for health care, contributed to by both federal and state / territory governments, distributed to the states and territories for the delivery of all health services on the basis of population and population health needs, should be given consideration as an arrangement that would deliver more efficient utilisation of funding, minimise disputes and provide better and more equitable health outcomes.