



australian  
nursing federation

## Submission to the National Health and Hospitals Reform Commission

---

June 2008

Gerardine (Ged) Kearney  
Federal Secretary

Lee Thomas  
Assistant Federal Secretary

Australian Nursing Federation  
PO Box 4239 Kingston ACT 2604  
Ph: 02-6232 6533  
Fax: 02-6232 6610  
Email: [anfcanberra@anf.org.au](mailto:anfcanberra@anf.org.au)  
Website: [www.anf.org.au](http://www.anf.org.au)

## 1. Introduction

- 1.1 The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses and midwives, with Branches in each State and Territory of Australia.
- 1.2 The ANF is also the largest professional organisation in Australia, with a membership of over 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 nursing.
- 1.3 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.
- 1.4 The ANF is pleased to have the opportunity to make a submission to the National Health and Hospitals Reform Commission. The ANF has been advocating for fundamental reform to the way health care is funded and delivered for several years, and has lobbied for the establishment of this Commission to consider and develop proposals for long term reform of our health system. The ANF has been a significant contributor to the national peak body, the Australian Health Care Reform Alliance (AHCRA), and strongly supports the views developed through consensus of this alliance. The ANF supports the AHCRA submission developed in response to the NHHRC Principles and Terms of Reference in May 2008.

## 2. The need for health reform in Australia

- 2.1 The evidence for the case for health reform has been building over several decades: the inflationary pressures in health care are great; our workforce is depleted and demoralised; access to health care is increasingly difficult for lower socioeconomic groups and those living outside metropolitan areas and Indigenous health outcomes are shameful. Unless these issues are addressed, preventable diseases threaten to see the next generation of Australians with a shorter life expectancy than their parents. The aged care sector also requires reform, with this important part of the health sector increasingly plagued by skill shortages, under-funding, and increasing risk to the safety and quality of care for frail and vulnerable residents.
- 2.2 Many reform advocates in Australia agree the entire system of health financing needs reform in order to deliver on community expectations of a service that is equitable, effective and accessible. One of the mechanisms popularly advanced to achieve this is to shift the current focus of the health sector from a hospital based, acute illness focus to that of primary health care, focusing on health promotion and illness prevention, to both reduce demand on the acute sector but also to improve health outcomes and reduce the levels of chronic illness and its associated effects on individuals and the population as a whole.

- 2.3 As the largest group of health care professionals, Australia's nurses are the backbone of the health and aged care systems, and reform proposals must consider using this highly skilled and valuable workforce in the most effective way possible. Nursing has a strong evidence base for reducing morbidity and mortality, and providing safe, effective, expert care. To be efficient, cost effective and sustainable, the future health system of Australia must fully utilise this profession by removing legislative, regulatory and professional barriers to nurses working to the full scope of their practice, and ensuring there are sufficient numbers of appropriately educated nurses to meet demand.
- 2.4 The health reform process should address a national review of health workforce education and models of care to explore ways of using our existing workforce more effectively. These are areas in which the medical profession has stubbornly resisted change, however ensuring a safe and effective health system into the future demands that these professional barriers are overcome.
- 2.5 Nurses want the health care system to be based on the principle of universal access to safe, quality, comprehensive and accountable health care. Nurses want to see a health system, public and private, that is fair, efficient, adequately funded and adequately staffed, where nurses can do the job they are educated to do - providing quality nursing care to the Australian community.
- 2.6 The ANF would like the health reform process to address:
- the implementation of strategies to create a positive workplace culture that supports the work of nurses, including effective nursing workload measures as means of recruiting and retaining nurses in the health system;
  - the removal of legislative, regulatory and professional barriers to nurses working to the full scope of their practice;
  - workforce planning to be linked to education to ensure there are sufficient numbers of appropriately educated nurses to meet demand;
  - the expansion of innovative models of care that are patient centred and based on a multidisciplinary approach;
  - duplication and inefficiency in health care funding through the consolidation of health funding arrangements with transparent lines of responsibility for funding and service delivery;
  - creating a universal health care system with access for all based on need rather than ability to pay;
  - reform of public sector financing for health services to ensure health care funding is directed to evidence based, effective interventions, with care delivered by the most appropriate health professional; and

- a particular emphasis on addressing the needs of severely disadvantaged groups and people with particular health needs in health reform proposals, such as Indigenous people, those in rural and remote areas, people with disabilities, and those who experience cultural, language, financial or other barriers in accessing services.

### 3. Summary of Recommendations

#### 3.1 That the Commonwealth Nursing and Midwifery Officer is given a mandate to:

- address all necessary strategies for an effective national nursing and midwifery workforce;
- implement a mechanism that will maintain and predict current and future nursing workforce demand;
- implement links between education and workforce to ensure proper education is provided; and
- establish a centralised method for co-ordinating nursing undergraduate clinical placement.

#### 3.2 That the Australian Government provides additional funding to universities to ensure undergraduate nursing courses:

- move to an interdisciplinary model of education;
- include primary health care in the curriculum; and
- facilitate multi-disciplinary models of practice.

#### 3.3 That COAG establishes a working group or independent body to:

- define the cost-benefits of employing adequate numbers of nursing staff;
- legislate for the licensing of all currently unlicensed health care workers;
- develop benchmarks that reflect the health outcomes that result from employing adequate numbers of nursing staff;
- develop, implement and oversee a system of national nursing workload measures;
- legislate to introduce minimum nurse staffing levels and skills mix requirements in all health care settings;
- undertake a national health funding audit to ensure funding is going to areas of need;
- develop and implement a national strategy to increase the number of positions for nurse practitioners;
- enact legislative reform to allow nurse practitioners to prescribe drugs and order diagnostic tests;
- investigate the efficiency and efficacy of using public funds to subsidise private health insurance; and
- implement the National Health Workforce Strategic Framework.

3.4 That the health system ensures the community has the best healthcare available through:

- the performance of a mapping exercise to establish where specific models of care are working and where it is possible to replicate them;
- the implementation of effective models of care that maximise the skills of our health workforce and deliver care to all Australians;
- the implementation of midwifery lead models of care in all jurisdictions;
- the development of mechanisms to facilitate reimbursement for consumers for services, prescriptions and referrals provided by advanced practice nurses, such as nurse practitioners, from publicly funded health budgets; and
- legislative change to allow funds to follow the consumer not the provider.

3.5 That the Australian Government ensures a fully utilised and comprehensively educated workforce by:

- providing employment incentives that are equitable in their distribution across health professional disciplines; and
- encouraging nursing research by allocating specific funding for distribution through the major research bodies.

3.6 That the Australian Government must, with regard to Indigenous health:

- increase the number of indigenous specific higher education facilities;
- commit further incentives and assistance to attract Aboriginal and Torres Strait Islander people to undertake a career in nursing;
- double the number of scholarships available; and
- promote the employment of indigenous people with particular attention to culturally safe interview and selection procedures.

3.7 That the Australian Government with regard to information technology:

- provide nationally accredited information technology education in nursing undergraduate courses;
- ensure that nurses are consulted in the development and implementation of health informatics; and
- ensure nurses have access to the internet at work.

## 4. Growing the workforce

- 4.1 The nursing and midwifery workforce is suffering huge shortages which are well documented. Additional places must be made available in the nation's universities if we are to be able to meet the health care demands of the community. At the same time however nursing education is thwarted by ageing infrastructure, a lack of clinical placements and a shortage of educators which is severely limiting the profession's capacity to meet workforce demands.
- 4.2 Efforts must be made to improve the links between education and workforce data to ensure Australia has measures in place to ensure we are training enough health professionals to meet the health and aged care needs of the community. Central to that is ensuring enough undergraduate places for nursing students; however eligible applicants by far exceed the places available at universities.
- 4.3 In addressing equity in health care, it is also important to ensure there is equity in the education of health professionals. Currently however the funding for health professional courses varies greatly, with medical professional courses receiving far greater proportion of funds than that of nursing and allied health, whose courses are equivalently expensive, sometimes more so.

This is because the current relativities and in particular the discipline groupings within the models of "clusters" for education funding for the health professions are disadvantageous for nursing and midwifery. The relative funding model which favours medicine over the other health professions was developed in 1980s and reflects historic funding patterns, but is not based on any contemporary evidence regarding the real or relative costs of delivering education for the various disciplines. Nursing education is currently funded at \$9,316 per Equivalent Full Time Study Load (EFTSL) compared to \$14,000 per EFTSL for medical students. However the resources required to teach the health sciences to nursing and allied health students are the same as those for medical students. The current inequity in funding relativities is forcing universities to consider abandoning nursing courses in favour of other courses which are less financially demanding. Increasing the funding available for nursing students would reflect the importance of the discipline and the urgency required in addressing national nursing workforce shortages.

- 4.4 The critical shortage of nurses in Australia warrants a significant increase in undergraduate and postgraduate scholarships, including Indigenous nursing scholarships. Currently, many nursing scholarship schemes are oversubscribed, with many more eligible applicants than available funding.
- 4.5 The work environment of nurses is inextricably linked to their role in influencing patient outcomes. However the processes and settings associated with nursing care are not always given the import they deserve in contributing to better patient outcomes. While the work nurses do is central to patient outcomes, the organisational environment in which they work has a significant impact on their ability to deliver safe, quality care.

There is substantial evidence to support the assertion that healthy work environments are linked to high quality patient care, and conversely that poor work environments contribute to adverse events and poorer patient outcomes. The costs to the community and to taxpayers through adverse events and increased length of stay as a result of excessive workloads and inadequate staffing in health care settings are well demonstrated by research; but the costs do not end there. There are significant costs to nurses themselves of understaffing, which are also well documented by American nursing researcher Linda Aiken and others. Some of Aiken's work on magnet hospitals has demonstrated important links between nursing leadership, nursing autonomy, respectful and collaborative relationships with colleagues from other professions, and a work environment in which their work was valued.<sup>1</sup>

- 4.6 Magnet hospitals have a demonstrated ability to attract and retain staff, as well as improve patient outcomes. The evidence base for magnet hospitals began in the 1980s when Margaret McClure et al discovered that in the midst of a global nursing shortage, some US hospitals demonstrated a substantially greater ability to recruit and retain professional nurses.

Known as "magnet" for their ability to attract nurses, these hospitals have particular organisational structures that recognise the importance of nurses throughout all levels of the hospitals administration and management from the top down. Magnet hospitals were found to be places where nurses had autonomy and control over their practice settings; good relationships with their colleagues; adequate support services; enough staff to provide high quality care; time to discuss patient problems with their colleagues; the opportunity to participate in policy decisions; a powerful nursing leader; and an environment that recognised the value of their work.<sup>2</sup> The ANF does not believe formal accreditation is necessary to achieve implementation of the magnet attributes for success in recruiting, retaining and empowering nurses.

The most substantial benefit of this organisational approach is that the improvement in the nurses' work environment improves recruitment and retention, improves the professional satisfaction of all staff, and improves safety and quality by reducing medical errors and preventable adverse patient outcomes.

- 4.7 The final issue that must urgently be addressed is the perceived lack of clinical placement for undergraduate nursing students. Clinical placement is an important part of the educative process for nurses. Too often we hear there are not enough clinical places, although with deeper examination recently it has been found that in New South Wales and South Australia that there are plenty of places available but the way the placement is organised lacks co-ordination and leadership.

Currently in New South Wales the Chief Nurse has implemented a centralised system for allocation and tracking of clinical placement and although in its infancy already it is proving an invaluable tool for ensuring that all nursing and midwifery students have access to high quality well timed exposure to the clinical setting.

## Recommendations

That the Commonwealth Nursing and Midwifery Officer is given a mandate to:

- address all necessary strategies for effective national nursing and midwifery workforce;
- implement a mechanism that will maintain and predict current and future nursing workforce demand;
- implement links between education and workforce to ensure appropriate education is provided; and
- establish a centralised method for co-ordinating nursing undergraduate clinical placement.

## 5. Higher Education

- 5.1 The higher education sector in most cases is given carriage for educating our health professionals and as a result it is necessary to give attention to the development of curricula to support greater demand for nursing roles in primary health care settings in the future.
- 5.2 Efforts should also be made to improve inter-professional learning across the health professions. This approach has been recommended by a number of international inquiries and studies (the ACT Health Inter-Professional Learning and Clinical Education Project, the Bristol Royal Infirmary Inquiry, the Southland District Health Board Inquiry in New Zealand, the King Edward Memorial Hospital (WA) Inquiry, and in the landmark review of patient safety, *To Err is Human*, by the Institute of Medicine in the USA) as an important feature of necessary health reform, because of its potential to improve the safety, quality and effectiveness of contemporary health care.<sup>3</sup>
- 5.3 The latter in particular referred to the need for interdisciplinary education to improve teamwork, and improve collaboration and communication between health professionals - all known to be key factors in improving patient safety and quality of care.
- 5.4 Inter-professional learning is seen as a particularly effective way of meeting contemporary health care needs through its capacity for developing interdisciplinary teamwork; improving collaboration between the professions and the patient; increasing the workforce skill mix; and supporting innovative work practices.
- 5.5 The need for collaborative and interdisciplinary education across the health professions is also recognised by the national policy document, the National Health Workforce Strategic Framework, developed by Australian Government, State and Territory Health Ministers in 2004. The framework espouses the benefits of teamwork, acknowledging that inter-professional teamwork is an important contributor to

positive health outcomes through the "improved communication, efficiency, cost-effectiveness, and the patient-centeredness of the health care team" and recognising that a "collaborative, multidisciplinary approach is needed to effectively tackle health workforce issues".

- 5.6 The concept of interdisciplinary education, while well established in other countries, is only just beginning to be explored in Australia, despite acknowledgement that more collaborative professional relationships would be beneficial for professional relationships and for patient outcomes.
- 5.7 The ANF recommends the incorporation of interdisciplinary education into the curricula of all the health professions, so a cooperative and collaborative approach to health practice between medical students and students of the other health professions is present right from the beginning of their careers. The development of inter professional competencies and the development of appropriate undergraduate, postgraduate, and clinical education curricula would also help promote and extend inter-professional cooperation. It is acknowledged however that further research should also be conducted into the effectiveness of the approach and its effect on patient outcomes.

## Recommendations

That the Australian Government provides additional funding to universities to ensure undergraduate nursing courses:

- move to an interdisciplinary model of education;
- include primary health care in the curriculum; and
- facilitate multi-disciplinary models of practice.

## 6. Retaining the workforce for better health outcomes and cost effective nursing

- 6.1 The risks posed to patients and nurses themselves when nurses are forced to work beyond the limits of safety with not enough staff, with an inadequate skill mix, and too many patients are considerable
- 6.2 Australian nurses find their job emotionally challenging, physically demanding, and stressful. Morale in the profession is low and deteriorating. They lack the autonomy necessary for professional satisfaction, and feel poorly valued by the health system and the community. They consider their pay rates to be poor, and their skills and experience unrewarded. They consider their working hours to be inconvenient, and while they value collegial support and teamwork, not all find it a feature of their workplaces. Nurses also consider their career prospects to be limited.<sup>4</sup>

*Nursing care saves lives, prevents complications, prevents suffering, and saves money.*

- 6.3 The effect of nursing care, nursing workload, nurse staffing and nurse education on the safety and quality of health care is now well documented. A huge body of evidence now exists to demonstrate the significant relationships between nurse staffing and patient outcomes; nursing workload and patient outcomes; nurses' work environment and patient outcomes; and between the skill mix of nurses providing care and patient outcomes.
- 6.4 Much evidence exists to demonstrate links between nursing care and the avoidance of adverse patient outcomes, such as urinary tract infections, pressure ulcers, pneumonia, deep vein thrombosis, falls, postoperative wound infections, medication errors, upper gastrointestinal bleeds, sepsis, increased length of stay (indicative of complications), and death.
- 6.5 There are also significant relationships between nurse staffing, nursing workload, and nurses' work environment and the wellbeing of nurses themselves: identified over and over again as stress, burnout, occupational injuries, and ultimately, a loss to the profession, the health sector and the community, when nurses are forced to choose to end to their professional career.
- 6.6 Every nurse that leaves the profession represents a loss of public funds, and treating nurses who are rendered ill or injured from their work is a financial cost to taxpayers too. There are on-costs for the community of nurses leaving nursing, as the education of every nurse is undertaken with public dollars, and each exit from the profession worth a loss of some \$AU150,000.<sup>5</sup>
- 6.7 The failure of governments and health care providers who employ nurses to recognise the implications of failing to invest in nursing is nowhere more profoundly demonstrated than in aged care. Increasingly registered and enrolled nurses are finding their services substituted by unlicensed and in many cases unqualified health care workers, particularly in the aged care sector where these workers now represent the bulk of the workforce providing care. Measures need to be taken to ensure the workforce has the skills and professional frameworks to ensure we don't continue to see reports regarding neglect, abuse, and inadequate care. Employing an unskilled and unregulated workforce is not only false economy but can potentially threaten the dignity and safety of one of the most vulnerable groups in our society - the frail aged.

*An obvious solution is to regulate the unlicensed worker, ensuring educational standards and ethical frameworks.*

- 6.8 Altering the skill mix of nursing staff is a practice often motivated by desire among service providers to drive down one of their major costs - that of staffing. However, as outlined by the research that appears both above and below, this can increase costs to the institution and to taxpayers. It also imposes costs on the recipients of care and nurses themselves.

Altering the skill mix by reducing the proportions of the most highly educated nurses in health care settings can have catastrophic and expensive results.

- 6.9 The impact of nursing care on the economic outcomes of health care is significant when the evidence is considered in regard to the costs of nursing turnover and the effect of inadequate staffing on patient outcomes, given that adverse events, preventable admissions and extended length of stay all contribute to considerable additional, and avoidable, costs.
- 6.10 These sorts of findings have profound implications for the health and wellbeing of the Australian community and should prompt an emergency response for all sectors of government to address this workforce crisis. In particular the federal government should legislate to introduce minimum staffing in all settings, including aged care, establish a mechanism to ascertain workforce figures that can usefully predict current and future workforce shortages, and introduce funding mechanisms that reflect and reward nursing care proportional to its value to the health sector and the health of the community.
- 6.11 In addition to minimum staffing levels and skills mix the other issue to assist retention is a strong and vibrant career path that provides for a nursing career at all levels and within all settings. One such example is the nurse practitioner. Nurse Practitioners offer a health care service that is unique in terms of their specific scope of practice. With the ability to initiate diagnostic tests, prescribe specified medications, and make referrals to other health professionals, they can provide a vital service and improve access to care. Nurse practitioners already provide a wide range of effective services either in primary health care as a generalist, or by providing specialist nursing services in, for example, mental health, emergency, community health, drug and alcohol services, wound care, and women's health as well as many other areas.

*A national approach to increasing the numbers of nurse practitioners in a wider range of practice contexts has the potential to improve access to care, and boost health care outcomes.*

- 6.12 However professional, regulatory, and financing barriers are inhibiting the practice of these expert nurses and preventing access to care. For example, without access to subsidised medicines, patients of nurse practitioners are unable to access subsidies from the Pharmaceutical Benefits Scheme for nurse practitioner generated prescriptions, and are therefore required to pay the full fee, often running into hundreds of dollars, while the same prescription from a general practitioner would either be completely subsidised or attract only a modest out of pocket fee.

*Removing these obstacles to the expansion of the role for nurse practitioners has the potential to improve access to care in all settings and improve the integration of all services through coordination of care.*

6.13 There is a strong potential for improving the primary health care services provided in aged care with this role - traditionally a difficult area to attract GPs to attend. Aged care providers who engaged the services of a gerontological nurse practitioner could prevent many unnecessary admissions to hospital through review and assessment, and delivery of appropriate interventions.

The model of nurse practitioner in aged care could help eliminate many of the problems associated with avoidable admissions to hospital from aged care providers who are unable to obtain the services of a general practitioner for assessment; medicines review; or the initiation of treatment that would most appropriately be described as primary health care, and would not require emergency admission to a (considerably more expensive) acute health care setting.

## Recommendations

That COAG establish a working group or independent body to:

- define the cost-benefits of employing adequate numbers of nursing staff;
- legislate for the licensing of all currently unlicensed health care workers;
- develop benchmarks that reflect the health outcomes that result from employing adequate numbers of nursing staff;
- develop, implement and oversee a system of national nursing workload measures;
- legislate to introduce minimum nurse staffing levels and skills mix requirements in all health care settings;
- undertake a national health funding audit to ensure funding is going to areas of highest need;
- develop and implement a national strategy to increase the number of positions for nurse practitioners;
- enact legislative reform to enable nurse practitioners to prescribe drugs and order diagnostic tests; and
- investigate the efficiency and efficacy of using public funds to subsidise private health insurance.

## 7. Ensuring the community has the best healthcare available

- 7.1 The health reform agenda offers an opportunity to consider an alternative model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model to offer comprehensive primary health care services. The current system of primary health care in Australia is not so much "primary health care" as "primary care".
- 7.2 Primary health care, as identified in the international Treaty of Alma Ata, involves an emphasis on prevention and health promotion, as distinct from the system of primary care familiar to most Australians as a trip to their GP. Primary care is better described as a "first contact" system rather than a system of primary health care; while the latter is characterised by a focus on the promotion of health and the prevention of illness, according to principles of equity, access, and community empowerment, and achieved by care delivered by multidisciplinary teams. However primary care more often than not "involves a single service or intermittent management of a person's specific illness or disease condition in a service that is typically contained to a time-limited appointment".<sup>6</sup>
- 7.3 The current system of primary health care funding in Australia however creates serious barriers to effective health promotion and chronic disease management, and is limiting its effectiveness in terms of equity, access and value for money. Major reform is needed. Current models of primary care are limited in focus, not always based on the best available evidence, and change has been driven by strategies that are more about political appeasement, rather than positive patient outcomes, efficient and sustainable service delivery models, or cost effective care.
- 7.4 The current system of primary health care is overwhelmingly skewed towards just one group of health professionals - doctors.

The fee for service system creates a perverse incentive to provide more, not necessarily better, services. It creates a financial incentive to provide many services, not make people better. It also acts as a barrier to integrated services: as a pay as you go model, there is nothing to oblige these services to interact with any other health service.

- 7.5 An example of a more effective model, for both people using the services and the professionals providing the services, is that of the community health centre approach, such as in some community health centres in Victoria, where salaried health professionals offer well integrated multidisciplinary patient centred care. People using the services are able to have comprehensive health care needs met by the most appropriate health professional, rather than the one who is the gatekeeper to the service, and health professionals have the benefits of working in a collaborative environment with support from their multidisciplinary colleagues and the satisfaction is working in a team to share the care of the community to whom they provide services.

- 7.6 Evidence suggests that this model is not only more cost effective than fee-for-service models, where costs blow out in an uncapped system,<sup>7</sup> but it provides for the delivery of high quality best practice care, as it offers greater scope for better utilisation of nursing skills in delivering a range of services that are responsive to community needs rather than that limited to services dictated by the Medicare Benefit Schedule item numbers available for practice nurse services.<sup>8</sup>
- 7.7 A centre such as the model of primary health organisations (PHO) in New Zealand for example, employing a range of health care professionals - nurses, doctors, allied health professionals, counsellors, dieticians, and psychologists, can provide a much more holistic and effective form of primary health care than a solo GP.
- 7.8 A true multidisciplinary primary health care model could be achieved through transforming, for example, the GP Superclinic model into a model where all primary care funds that would otherwise be made available to that service were cashed out, local governance processes installed to ensure the services was responsive to local needs, and all services paid through a salaried model, with staff employed by the state government.
- 7.9 The ANF does not support the current model of GP Super Clinics proposal as it is currently proposed as does not offer anything in terms of a new model of care but is simply a new method of funding GP services by using Australian Government funds to support the development of infrastructure for GP services.

The GP Superclinics model claims to offer "accessible and affordable care", and it understood these clinics are being established in areas of need, where access to primary health care has been limited, where existing GPs may have closed their books, or where no GP currently practices. However there is no assurance that this model will deliver "accessible and affordable care", as there is no obligation on the participating GP to bulk bill, and people who are currently denied access to care as they cannot afford the out of pocket costs will be no better off.

- 7.10 Accessibility is unlikely to improve as the model using fee- for-service funding almost entirely from the MBS is already well demonstrated as posing risks of assuming a "six minute medicine" approach to health care; where the GP (being the only member of the team able to directly access funds is overworked); other team members are undervalued and reluctant to work in the practice; and ultimately the same problems that plague general practice now in outer metropolitan, regional, and rural areas will re-emerge, and GPs (just as they are now) will be reluctant to work in the area.
- 7.11 The ANF is also concerned that the use of small streams of recurrent funds for the employment of nurses in this model is unlikely to create a sustainable model for employment, and is likely to serve only to diminish the value of the work of nurses, and therefore have a negative effect on their wages.

7.12 It may be possible to transform the GP Super Clinics into an innovative model of care, but in order to do so consideration must be given to an appropriate funding mechanism for the delivery of comprehensive primary and preventative health care by multidisciplinary teams. This would be a responsive, accessible, equitable and affordable primary health care model that would deliver better health outcomes for the community. A true multidisciplinary comprehensive primary health care service could showcase the highly sophisticated clinical support that can be offered by advanced practice nurses and nurse practitioners functioning autonomously as a member of the multidisciplinary team in the a range of primary health care and preventive services such as chronic disease management, mental health, healthy kids checks, health promotion, health education and wellness programs. Access to a recurrent source of funding based on a capitation model would help address the anomaly that exists with the current MBS items numbers which ignored the autonomous nature of nursing practice in reimbursing general practitioners for services provided by a nurse.

*As regulated health professionals, nurses work collaboratively with other health professionals, not under the 'supervision' or 'for and on behalf of' the GP. Recognising this for what it is: the efforts of the medical profession to control the flow of funds under the guise of directing the practice of others, and reforming the funding system to address it, are essential for responsive primary health care that will meet the needs of Australians.*

7.13 Nurses are an integral part of the solution in efforts to integrate and coordinate care in all aspects of the health sector, but because of their intrinsic role are particularly well positioned to do so between the hospital and acute sector to improve key measurable outputs for health.

There is increasing evidence of the effectiveness of nurse-led care in primary health care settings<sup>9</sup> indicating that nurses can not only provide effective care, with positive health outcomes, but nurse led care involves higher levels of patient satisfaction and higher quality of life.

7.14 Another example of where primary health care could be strengthened is that of midwifery services. The majority of women can be safely cared for by a midwife, before, during, and after a birth. Midwives are the most appropriate carers for women with uncomplicated pregnancies, labour and birth. If women have a known midwife throughout their pregnancy and labour, they have a much higher chance of having a spontaneous, uncomplicated, birth. An Australian study of more than one million births Dr Tracey published in 2007 found babies born in midwife-run birth centres had significantly lower death rates than those born in hospitals. The review of all births in Australia from 1999 until 2002 confirmed the centres provide care that is as safe, if not safer, as standard maternity units.<sup>10</sup>

Much more evidence exists, all of it underscoring the point that due to professional boundary issues and the unwillingness of the medical professional groups to acknowledge the value and efficacy of midwifery care, governments have been reluctant to support service delivery models that make best use of this valuable resource.

7.15 Women in Australia have one of the highest rates of obstetric intervention in the world<sup>11</sup> - an issue that, if the terms of reference of this Commission to "develop a long term reform plan to provide sustainable improvements in the performance of the health care system" are to be addressed, should be considered an urgent priority to protect the safety and quality of care for women and babies.

Efforts should be made to implement models of care that allow all women access to publicly funded midwifery services.

*New funding initiatives are needed to facilitate midwifery led models of care in all jurisdictions.*

## Recommendations

That the health system ensures the community has the best healthcare available through:

- the performance of a mapping exercise to establish where specific models of care are working and where it is possible to replicate them;
- the implementation of effective models of care that maximise the skills of our health workforce and deliver care to all Australians;
- the implementation of midwifery lead models of care in all jurisdictions;
- the development of mechanisms to facilitate reimbursement for consumers for services, prescriptions and referrals provided by advanced practice nurses, such as nurse practitioners, from publicly funded health budgets; and
- legislative change to allow funds to follow the consumer not the provider.

## 8. Rural and remote services

8.1 The recent rural health workforce audit clearly demonstrates that nurses and midwives are "holding the fort" in rural and remote primary health care, yet there is still a failure to recognise their contribution in the development of national health policy to remove the professional boundaries, legislative barriers, and lack of support nurses experience which are limiting effective delivery of care.

8.2 With around 80,000 nurses working in these locations, nurses are by far the most geographical well distributed health care professionals, in sharp contrast to their medical colleagues, whose numbers decline significantly as remoteness increases. Creating a health funding system that recognises the values and capacity of nurses and facilitated the delivery of care through multidisciplinary teams would help to alleviate some of the problems with access to care in rural and remote areas. It is also important to ensure that incentives available to doctors are also available to nurses, midwives and other health professionals, for example locum support,

scholarships for ongoing education, and incentives to relocate to rural and remote areas for example. A comparison of available incentives to rural and remote health professionals is provided at Attachment A (nursing) and Attachment B (medical).

- 8.3 There are ongoing difficulties for rural and remote area nurses in accessing ongoing education and professional development. The ability of nurses to attend educational events relates directly to the availability of appropriately qualified and readily available relief staff, as well as obtaining leave from their workplace.
- 8.4 Additional challenges to attend educational events include the distance to be travelled, inflexible learning environments, and unrealistic expectations relating to clinical practice and learning opportunities. Many nurses use valuable long service leave and holiday entitlements to attend courses. These issues continue to provide barriers for ongoing education.
- 8.5 Without sufficient scholarship funds to increase the number of nurses in remote and rural areas and to cover the real costs associated with learning activities, whether undergraduate or for professional development, there is limited opportunity for nurses practising in rural and remote areas to obtain ongoing education.

## 9. Research capacity

- 9.1 A thirty year program of academic inquiry and scholarship in Australia and internationally has led to a highly qualified and skilled nursing workforce, educated within a framework that offers the opportunity for nurses to apply their high level critical thinking skills to deliver effective evidence based interventions, as well as evaluate their practice, and build on the significant body of knowledge that informs nursing practice through investigation and research.
- 9.2 However nursing research does not receive a level of funding proportional to its size or capacity in providing health services. Research in nursing is vital for ensuring optimum patient care and evidence based practice. As a unique discipline, nurses need to be able to use research to allow them to further their understanding of nursing practice and further their contribution to patient care. Research allows nurses to question, evaluate and analyse nursing practice, and critically investigate with the aim of improving practice and thus patient outcomes.<sup>12</sup>
- 9.3 The 2002 report, *Our Duty of Care*, from the National Review of Nursing Education, highlighted the importance of nursing research and the development of nursing researchers for sound health policy decision-making and improvements in clinical nursing practice and education. It identified building nursing research capacity and facilitating the application of that research as vital for more efficient, effective health outcomes from nursing work and to the delivery of quality education to nurses.<sup>13</sup>

*Additional, targeted investment in nursing research is necessary to continue to expand the evidence base of nursing and midwifery in order to improve patient outcomes and contribute to national health and wellbeing.*

## Recommendations

That the Australian Government ensures a fully utilised and comprehensively educated workforce by:

- providing employment incentives that are equitable in their distribution across health professional disciplines; and
- encouraging nursing research by allocating specific funding for distribution through the major research bodies .

## 10. Indigenous health

10.1 Indigenous health provides unique challenges and it is vital that every effort is made to strengthen the Indigenous workforce to ensure the delivery of culturally appropriate care. This requires the encouragement of as many Indigenous people as possible entering health careers by offering supported pathways to education and increasing investment in Indigenous educational places. Expansion of programs such as the Koort Mooditj pre-nursing program which prepares Aboriginal and Torres Strait Islander students for first year nursing studies and the Marr Mooditj which has dedicated itself to educating Indigenous people in primary health care are two good examples of how this can occur.

10.2 Increasing the rollout and facilitating access to more programs such as this would assist in the development of an appropriately trained, culturally sensitive workforce to address the appalling health outcomes of Australia's Indigenous community.

10.3 Additional scholarships should be made available to encourage Indigenous students to undertake health careers. The number of Puggy Hunter scholarships should immediately be doubled and increased over time to better address the relativities in shortfall so that the proportion of Indigenous health nurses to Indigenous people reaches or exceeds that of the proportion of nurses to 100,000 population in all geographical areas. Special consideration should be given to initiatives to encourage the development of Indigenous Nurse Practitioners.

10.4 Indigenous Australian and Torres Strait Islander people should have equal access to nursing education through an Australian Government commitment to further incentives and assistance to attract Aboriginal and Torres Strait Islander people to a career in nursing. Cooperative efforts with states and territories to improve career pathways from schools into training and education in the health sector are needed. This could include promotions in schools with significant Indigenous populations to encourage Indigenous students to consider a career in health care, as well as the promotion and implementation of indigenous nurse and midwife employment strategies, with particular attention given to culturally safe interview and selection procedures.

10.5 Addressing the education of health professionals to ensure the inclusion of Indigenous history and cultural issues is important to the provision of culturally appropriate care. Content relevant to the history and culture of Indigenous Australian and Torres Strait Islander people and including social justice issues should be integrated in all undergraduate curricula for nursing students as well as other health professions. Indigenous Australian and Torres Strait Islander people should be involved in the development of guidelines for Indigenous content in curricula.

10.6 Engaging Aboriginal and Torres Strait Islander RNs as consultants to faculties of nursing, to act as educators and mentors can assist in this. There should also be an emphasis on obtaining as many placements for nursing students as possible in an Indigenous community or Indigenous community health organisation, carefully and thoroughly arranged with each participating community.

10.7 The ANF recommends the implementation of the recommendations of the report into Indigenous nursing education in 2002, '*Gettin em n Keepin em*', available at [www.indiginet.com.au/catsin/images/get%20em1.pdf](http://www.indiginet.com.au/catsin/images/get%20em1.pdf).

10.8 The ANF strongly supports the Close the Gap initiative and is committed to advocating for solutions that will support the development of Indigenous health care workforce to ensure the delivery of culturally appropriate care. Indigenous Australian and Torres Strait Islander community controlled health services are supported and promoted within their communities.

## Recommendations

That the Australian Government must, with regard to indigenous health:

- increase the number of indigenous specific higher education facilities;
- commit further incentives and assistance to attract Aboriginal and Torres Strait Islander people to undertake a career in nursing;
- double the number of scholarships available; and
- promote the employment of indigenous people with particular attention to culturally safe interview and selection procedures.

## 11. Information Technology

- 11.1 It is essential that there is a coherent national strategy for capacity building and education of health professionals concurrent with the roll-out of clinical information systems. However significant barriers exist to the effective use of information technology by nurses and midwives.
- 11.2 A study of 10,000 nurses by the ANF released last year found that, although nurses recognise the benefits of adopting more information technology in the workplace, they are frustrated by limitations of access, software that is not always fit for purpose, and lack of opportunities for training.
- 11.3 The level of use of information technology among nurses and midwives is low and confidence is low even among those nurses who are users. The aged care sector scored the lowest on all parameters studied. The study found that nurses feel poorly informed about information technology health initiatives and poorly consulted about their implementation.
- 11.4 Workload, number of computers, inadequate technical support and lack of training are the principal barriers to the use of information technology. Technical support is especially poor in more remote locations. Nurses feel the full potential of information technology use in the provision of health and aged care will not be realised until these limitations are addressed.
- 11.5 As the largest single profession in the health workforce, nurses manage patient information continuously and it is critical they are familiar with IT systems for e-health initiatives such as clinical decision making, health care records and care plans.

*As a major user group of e-health technologies nurses and midwives can greatly influence the efficacy and implementation of systems in health and aged care settings.*

However there has been limited engagement with the nursing profession by key stakeholders in the e-health agenda to date.

- 11.6 An understanding of nursing's contribution to health care outcomes is vital in ensuring that clinical systems being implemented reflect the needs of nursing clinicians in terms of capturing data that reflects their contribution and/or subsequent patient outcomes.
- 11.7 There should be a significant investment in IT education and training for the nursing workforce for e-health systems being developed and implemented at the jurisdictional levels to ensure clinical information systems have semantic interoperability. It is important that tertiary nursing providers include nursing informatics at both undergraduate and postgraduate levels. Providers of nursing education should be given support to continue to provide nursing informatics competencies within core content of undergraduate curricula as well as to offer postgraduate studies to build unique expertise within this specialty in Australia.

11.8 The shift to electronic health records is likely to have a significant impact on the immediate future working environment for nurses; it is likely to have significant effects on the way care is delivered; and affect the future skill mix of the nursing workforce. It is vital that nurses are engaged with the issues associated with the development and roll-out of clinical communications systems to ensure the unique discipline of nursing, and its interventions and associated outcomes, are accurately captured by the clinical information systems being implemented.

11.9 The ANF supports the recommendations of the study that call for the development of national information technology competency standards for nurses and their incorporation into all nursing courses and the adoption of a national information technology standard for nurses in Australia, such as the international computer "driving license".

## Recommendations

That the Australian Government with regard to information technology:

- provide nationally accredited information technology education in nursing undergraduate courses;
- ensure that nurses are consulted in the development and implementation of health informatics; and
- ensure nurses have access to the internet at work.

## 12. Specific feedback on principles

12.1 The ANF generally supports the draft Principles but supports the AHCRA position that there is value in developing key principles that are values-based to underpin the system to ensure that health policy is able to be tested against the principles. The ANF wishes to be closely involved with the process involved in validating and actioning these principles and looks forward to contributing to further consultations with the NHHRC.

---

### NHHRC Principles

### ANF Response

---

People and Family Centred

The ANF supports this principle and acknowledges that pathways of care are often complex and confusing for consumers. The principle explanation should also make explicit reference to informed choice and control over choices. Any reform must include options for consumers to receive optimal care in the most favourable environment for the health consumer.

---

Equity

The ANF supports this principle. The reference to closing the gap is considered important and supported.

---

---

NHHRC Principles	ANF Response
Shared Responsibility	The ANF acknowledges that healthcare cost is not an infinite resource and supports the principle that involves "choice" and shared responsibility for consumers.
Strengthening Prevention and Wellness	ANF supports this principle, provided there is adequate funding for realistic and appropriate illness prevention and wellness programs that include services and programs for the frail elderly and disabled, Indigenous and marginalised communities. The importance of comprehensive primary health care in achieving this should be acknowledged.
Comprehensive	The ANF supports this principle however it should refer to the need for, and obligation to provide, health care services for the entire continuum of life, including the range of settings through which this can occur.
Value for Money	The ANF supports this principle. Suggest merging with the following principle.
Providing for Future Generations	The ANF supports the principle. It is suggested that it also refer to the need for a dynamic health policy environment to ensure education, workforce, and research in health are able to adapt to meet community needs as they change over time.
Recognise Broader Environmental Influences which Shape our Health	The ANF supports this principle. It is suggested that it also address the necessary issue of the effect of the environment on health.
Taking a Long Term View	The ANF agrees that any reform to the nation's health and hospital system must include planning for both present and predicted needs.
Safety and Quality	The ANF strongly supports the principles of safety and quality in our national health system, and the need for high level organisational systems to support and promote this principle. This should also include appropriate resourcing (including human resources), appropriate services (care provided by the most appropriate health professional), and appropriate care (the extent to which the care is clinically appropriate/evidence based/likely to be effective).
Transparency and Accountability	The ANF supports a system that is both transparent and accountable.

---

---

NHHRC Principles	ANF Response
Public Voice	The ANF supports this principle. It is important to also reflect here the engagement of consumers beyond having a voice to the true engagement of the community in the planning, development and delivery of health services.
A Respectful and Ethical System	The ANF strongly supports this principle.
Responsible Spending on Health	The ANF supports this principle.
A Culture of Reflective Improvement and Innovation	The ANF supports this principle.

---

### 13. A Future Role for a National Health Reform Commission

13.1 ANF considers that there is an ongoing, long term role for an independent National Health Reform Council or Commission that should extend beyond the proposed term of the NHHRC which should have a permanent role in coordinating the development, implementation and evaluation of national health policy.

13.2 The permanent Commission will:

- oversee the development and implementation of a new nationally integrated system for financing health care in Australia;
- develop a national health policy to provide a framework for the development of coherent national health policies that plan for future needs;
- be responsible for coordinating national workforce data collection, national workforce planning and workforce innovation as recommended by the Productivity Commission;
- provide for a common national language for targets, benchmarks, and data collection to facilitate the evaluation and reporting of health expenditure and health outcomes;
- outline cost effectiveness by performing and regularly reporting a cost benefit analysis of all health services at both the provider and institutional level;
- publish and make available comprehensive evaluation of outcomes of care from all health services - including acute, primary health care, community, public and private;
- develop an index of fair health financing;

- develop a resource distribution formula to guide health spending according to population health needs, taking into account factors such as cultural, socioeconomic status, disability etc;
- commission research to fill knowledge gaps in relation to reform;
- develop a framework for "Health Impact Statements" to evaluate the effect of government policies on health status and health outcomes;
- collaborate with other agencies such as the Australian Commission for Safety and Quality in Health Care, and the National E-health Transition Authority;
- oversee the implementation of the National Health Workforce Strategic Framework;
- oversee the implementation of the National Aboriginal Health Strategy and the National Aboriginal and Torres Strait Islander Health Strategy; and
- develop and oversee the development and implementation of a national primary health care policy and a national rural and remote health policy, and regularly evaluate and report on their effectiveness.

## 14. Conclusion

14.1 The ANF thanks the National Health and Hospitals Reform Commission for their efforts in undertaking the process of developing a long term health reform plan. The ANF is looking forward to further contributing to the process of health reform through involvement in planned consultations with professional groups. We would be pleased to provide any further information the Commission requires in relation to this submission to support the development of reform proposals.

## References

1. Aiken, L., et al. 2002. Superior outcomes for magnet hospitals: The evidence base, *Magnet Hospitals Revisited: Attraction and retention of professional nurses*, McClure and Hinshaw (eds), Washington DC, American Nurses Publishing.
2. Donley, R. and Flaherty, M.J. 2002. Revisiting the American Nurses Association's First Position on Education for Nurses, *Online Journal of Issues in Nursing*, 7:2.
3. Braithwaite and Associates 2005 *The ACT Health Inter-professional learning and clinical education project: background discussion paper #3*. ACT Health Department.
4. Hegney, D. et al. 2006. Extrinsic and intrinsic work values: Their impact on job satisfaction in nursing, *Journal of Nursing Management*, 14(4): 271-278.
5. Australian Nursing Federation, *Nurses' Paycheck: A comprehensive analysis of nurses' wages*, Dec 2007-February 2008
6. Keleher, H. (2001) 'Why primary health care offers a more comprehensive approach for tackling health inequities than primary care'. *Australian Journal of Primary Health*, 7(2), 57-61.
7. McDonald, J. et al. Systematic review of comprehensive primary health care models, Australian Primary Health Care Research Institute, September 2006.
8. Keleher, H. et al. Review of primary and community care nursing, Australian Primary Health Care Research Institute, November 2007.
9. Keleher, H. et al. Review of primary and community care nursing, Australian Primary Health Care Research Institute, November 2007.
10. Kathleen Fahy RM PhD (UQ), Sally K Tracy DMid RM (2007) Critique of Cochrane systematic review of home-like setting for birth, *International Journal of Evidence-Based Healthcare* 5(3) , 360-364.
11. Caroline M de Costa, Caesarean section: a matter of choice? *MJA* 1999; 170: 572-573.
12. ibid
13. ibid
14. <http://www.anf.org.au/it%5Fproject/>