Australian Nursing & Midwifery Federation

Submission to Primary Health Care Advisory Group Discussion Paper: Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care

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The industrial and professional organisation for Nurses, Midwives and Assistants in Nursing in Australia

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Executive summary

The Australian Nursing and Midwifery Federation (ANMF) welcomes the opportunity to provide advice to the Primary Health Care Advisory Group (PHCAG) to guide its deliberations on better outcomes for people with chronic and complex health conditions. Nurses and midwives are the largest component of the primary health care workforce. The management of people with chronic and complex conditions is undertaken by a significant cohort of the ANMF nursing and midwifery membership.

The position taken by the ANMF is that the 'front-end' of health care, that is, early intervention, prevention, and health promotion activities, greatly diminishes the need for expensive 'back-end' or chronic disease management strategies. Further, we believe that the main thrust of policy and funding drivers should be on the 'front-end' or mitigating activities, to rein in the growth of chronic disease in this country.

The ANMF maintains that a well-structured, well-resourced and responsive primary health care sector should be central to this country's health care system and chronic disease management. Essential elements of an effective primary health care system are: a team based approach to service delivery; accessibility for all communities; cultural appropriateness; fostering of community participation; adequate funding to support services which meet the communities' health and aged care needs; support for education and on-going professional development requirements of the health care professional team; and sustainability, flexibility and responsiveness to the community.

Our recent submission to the House of Representatives Standing Committee on Health Inquiry into best practice in chronic disease prevention and management in primary health care (Appendix A), is pertinent to the PHCAG's deliberations. We therefore forward that submission, which should be read in conjunction with our response to the PHCAG.

The ANMF considers it is essential this opportunity for reform of the primary health care environment does not perpetuate more of what we have now. We need changes which will enable innovation. With the increasing age of our population and increasing rates of chronic and complex disease, we need to re-think the way primary health care is delivered. Nurses and midwives are key to this change. The system needs to provide the option for nurses and midwives to contribute their intrinsic care which is delivered the way individuals and the community wants and needs. Nurses and midwives clearly understand and address the social determinants of health and how these affect the health of individuals and their community. Nurses and midwives are best placed to be care co-ordinators with their innate philosophical approach to connect individuals to the right treatment or refer them to the right health professional when required.

Recommendations to the Primary Health Care Advisory Group

The Australian Nursing and Midwifery Federation recommends that:

1. The focus on health care in this country be on prevention, early intervention, and direct easy access to appropriately qualified and skilled nurses, midwives and other health care professionals.

Effective and Appropriate Patient Care

2. The PHCAG take the opportunity to implement a model of primary health care that extends beyond general practice (primary care) to a multidisciplinary model which offers comprehensive, person-centred primary health care services.

3. Dedicated registered nurse care co-ordinator roles be established in primary health care for people with chronic and complex conditions.

4. That a ‘health care home’ be a practice in the broader sense of the word. The ‘health care home' should be any primary health care service of the person's choosing to allow for a range of services and health care professionals to fulfill this role.

Increased use of Technology

5. In addition to expanding the use of technology as a communication tool, funding incentives are provided to improve communication processes between health professionals and across all health care sectors.

6. Advances in technology do not obviate the need for better verbal and written communication channels.

7. The use of telehealth technology is encouraged to promote better access to primary health care services, specifically for people in rural and remote regions with chronic and complex conditions.

Achievement of Outcomes

8. Health outcomes be measured and reported against the individually agreed management plans for people with chronic and complex conditions, taking into account impacting factors contributing to a person's health status.

Payment mechanisms to support a better Primary Health System

9. There be a blended payment system for funding primary health care including a mix of fee-for-service, pre-payment and payment for performance with salaried arrangements.

10. Funding models be developed in which the funding follows the person, and aligns with the care requirements for that individual, in order to provide better access to a range of health care professionals and services within primary health care.

11. Funding models provide for positive health outcomes for communities, through sound health policy and designed to meet population needs.

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12. The Commonwealth funding models be developed in conjunction with State/Territory governments to reduce gaps in service or unnecessary overlap.

13. Funding be provided for designated nurse practitioner positions in the primary health care public sector, including small rural and remote communities.

14. There be access to ‘request and refer’ MBS provider numbers for nurse practitioners in the primary health care public sector, as is the case for medical interns in the tertiary setting.

15. There be a substantial increase in the payment for MBS items for nurse practitioners in primary health care private practice to enable them to establish a viable and sustainable practice.

16. Recurrent incentive funding be provided for nurse practitioners in primary health care private practice to work in areas of designated District Workforce Shortage.

17. Infrastructure funding be provided for nurse practitioners to establish primary health care private practices.

18. Funding models allow nurse practitioners to employ other nurses under the Practice Nurse Incentive Payment (PNIP) in the same way as General Practitioners.

Introduction

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership which now stands at over 249,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Nurses and midwives together comprise more than half the total health workforce. They are the most geographically dispersed health professionals in this country, providing health care to people across their lifespan and in all socio-economic spheres. The fact that nurses and midwives form the largest component of the health and aged care workforce is especially evident in primary health care settings. Primary health care is fundamental and inherent in the philosophical base of the disciplines of nursing and midwifery. The ANMF maintains that positioning primary health care at the centre of health policy should lead to significant improvements in health for all people in Australia, and through all stages of life.

A significant number of ANMF members practice in primary health care settings, including, but not limited to: homes, schools, communities (including maternal and child health), general practice, local councils, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health

services, the armed forces, universities, mental health facilities, occupational health, sexual health, and women's and men's health. These nurses are engaged in early intervention, prevention and health promotion activities to prevent or mitigate against the occurrence of chronic diseases, and in assisting clients in their management of established chronic and complex health conditions.

The ANMF, therefore, takes the opportunity to provide advice to the PHCAG for its deliberations on better outcomes for people with chronic and complex health conditions through primary health care.

General Comment

It is the firm view of the ANMF that a well-structured and well-resourced primary health care sector should be central to Australia's health care system. In keeping with the international Alma-Ata Declaration of 1978 on primary health care[1], aspects of a person's health must be considered within the broader social context of that person. Further, that individuals and communities have a right to participate in the planning and implementation of their health care. This is the essence of the primary health care system that we should be aspiring to, delivered by a range of health care professionals working as a team.

An effective primary health care system is one which is: accessible to all communities, culturally appropriate, involves community participation, is adequately funded to support the services needed to be delivered to meet the communities' health and aged care needs and to support the educational and ongoing professional development requirements of the health care professional team. Embedding a well-established primary health care sector within the country's approach to health care has a twofold benefit in that there is reduced demand on the acute care sector while at the same time improvement to health outcomes and population health and well-being.

[1] International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. *Alma-Ata Declaration 1978 on Primary Health Care*. Available at: http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

ANMF personnel attending the PHCAG consultation forums, recently held around the country, have witnessed a continuing misunderstanding of roles and functions within the primary health care system. The ANMF maintains there is a difference between primary health care and primary care, a position that is shared across the nursing and midwifery professions. In 2009 the then ANF, as part of a group of leading nursing and midwifery professional organisations, developed a consensus view on primary health care in Australia (Appendix B). This consensus view argued that primary care and primary health care "generally represent two different philosophical approaches to health care", and, that primary care is a subset of primary health care.[2]

This difference between 'primary health care' and 'primary care' is as follows:

Primary care

> *…is commonly considered to be a client's first point of entry into the health system if some sort of active assistance is sought.*
>
> *…is general practice and is the heart of the primary care sector.*
>
> *…involves a single service that is typically contained to a time limited appointment, with or without follow-up and monitoring or an expectation of provider-client interaction beyond that visit*.[3]
>
> …is almost always delivered in isolation from the broader framework of the social determinants of health.
>
> …has a focus on diagnostics and treatment.[4]

Primary Health Care

> *…has a focus on social rather than a medical model of health; is essentially about social justice and is inter-sectoral in that health care services operate in collaboration with the many other sectors impacting on human health.[5]*

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[2] Australian Nursing Federation. 2009. *Primary health care in Australia: a nursing and midwifery consensus view*. Available at: http://www.anf.org.au

[3] Keleher, H. 2001. 'Why primary health care offers a more comprehensive approach for talking health inequities than primary care'. *Australian Journal of Primary Healt*h. Vol 7(2): p.57-61.

[4] Carryer, J. and Yarwood, J. 2015. The nurse practitioner role: Solution or servant in improving primary health care service delivery. Collegian (2015) 22, pp.169-174.

…deals with the main health problems and issues experienced by the community. It may include care and treatment services, rehabilitation and support for individuals or families, health promotion and illness prevention and community development.

…is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community…at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

…brings health care as close as possible to where people live and work.

…acknowledges a social view of health and promotes the concept of self-reliance to individuals and communities in exercising control over conditions which determine their health.[6]

The importance of highlighting the distinction between the two is that there are a significant number of health professionals working beyond general practice (primary care), the majority of whom are nurses and midwives. And, many people who only ever integrate with services beyond general practice (primary care). If conversations deliberately or unintentionally focus solely on general practice (primary care), the outcomes of the PHCAG will be redundant to the broader primary health care sector – and the community's health will be severely compromised. The PHCAG's work presents the opportunity to think about a model of primary health care that extends beyond general practice (primary care) to a multidisciplinary model that offers comprehensive, person-centred primary health care services. This opportunity must not be wasted by perpetuating antiquated notions of care delivery and concomitant funding mechanisms.

[5] Carryer, J. and Yarwood, J. 2015. The nurse practitioner role: Solution or servant in improving primary health care service delivery. Collegian (2015) 22, pp.169-174.

[6] Australian Nursing and Midwifery Federation. 2015. Position statement: Primary Health Care. Available at: http://www.anmf.org.au

A variety of responsive forms of service delivery, provided by a range of health professional providers, including nurses and midwives, must be available to meet the needs of all people, including those with special needs such as cultural or language barriers, intellectual disability and chronic and complex conditions.

Whilst due acknowledgement is given to the important role general practice plays in primary care (assessment, diagnosis and treatment), this is just one component of the primary health care model, with its broader remit for health promotion, intervention and illness prevention. There are fewer general practices the more rural and remote one travels in Australia, with nurses and midwives becoming more predominant in providing health services for these communities. As will be discussed later, funding models must be more responsive to the range of health professionals engaged in all aspects of the primary health care sector.

Better outcomes for people with chronic and complex conditions

The commentary to follow responds to the specific issues considered in the PHCAG discussion paper: *Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care*.

Introduction Questions – What is the problem?
What aspects of the primary health system work well for people with chronic and complex health conditions?
What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

What is the problem?
What aspects of the primary health system work well for people with chronic and complex health conditions?

The answer to both of these questions is quite simply ‘care co-ordination’. It works well for people with chronic and complex health conditions where this is in place, and where this does not occur, it creates a serious gap in care. As discussed under the response to Theme 1, the ANMF contends the registered nurse is the most

appropriate health professional to undertake the person centred care co-ordination role. This is because the role requires the generic underpinning of being a clinician. The education level of a registered nurse is needed to guide the clinical decision making required for intelligent, evidence-based prioritising of the order of events to be co-ordinated. The registered nurse is well placed in the health care setting to maintain all elements of case management/care coordination for the health consumer as they have a sound understanding of service models, health care funding streams, health service and government health priority areas. The clinical and technical expertise of the health system, the interconnectivity of nursing to other health disciplines and no conflict of interest in deciding what other services are appropriate in terms of access and affordability, for the optimal care outcomes for the recipient of health care. The care co-ordination role will be re-visited under Theme 1.

As the Discussion paper states, "*the primary health care system can provide community-based, multidisciplinary and patient-centred care. For these reasons it is the best setting for the prevention and management of chronic and complex health conditions"*. The ANMF would not disagree with these sentiments. However, the system is currently not enabled to do what is outlined in this statement.

The biggest barrier we see to the primary health care system not being able to fulfil its potential is the focus by governments on a subset of primary health care, that is, general practice (primary care). It seems incongruous that a privately established primary care sector receives an enormous contribution from the public purse to fund services, which do not always meet population health needs. There is a mishmash of private and public services at play in the current primary health care system in Australia that creates tension for health professionals involved in care provision.

In the absence of a national health system for the primary care component of the primary health care system, such as in the United Kingdom, we need to acknowledge that there will always be some degree of tension (especially communication issues) because of the public and private split in service delivery. For example, a woman may visit the maternal and child health centre for advice and immunisations for her

child and attend a private General Practitioner for complex health issues. Even with e-Health capabilities in each facility there will be some information that is unable to pass between the private and public divide. It is primarily for this reason that the data about an individual should reside with that individual, as they are the common denominator in moving between different parts of the health/aged care/disability/maternal and child health sectors.

With reference to the Guiding Principles (p.7 of the discussion document), the ANMF requests an 8th principle be included, as follows:

> *Provide flexibility in service delivery to accommodate ALL people living in Australia – that is, regardless of geography, socio-economic status, cultural group, gender orientation, Indigenous/non-Indigenous.*

Our rationale derives from the Alma-Ata Declaration of 1978 concept of bringing health care as close as possible to where people live and work, and, we would add "to who they are".

The aspects of the primary health care sector which currently work well for people with chronic and complex conditions are those in which the health professionals are connected enough with their clientele to know what services they need (being responsive to the health needs and not driven by funding mechanisms) and what they can afford to pay. Examples are:

- Community/District nursing services
- Health independence programs
- Multi-Purpose Services (MPS) in rural areas
- Aboriginal Community Controlled Health Organisations
- Nurse-led clinics – for example diabetes; cardiac care, asthma management
- General practice where there is teamwork. We know from our members it is most often the nurses who are undertaking care planning and chronic disease management.

Exemplar of team approach:

Nurse Practitioner Lesley Salem, NSW – a generalist and chronic disease NP who works particularly with Aboriginal and Torres Strait Islander people and those with socioeconomic disadvantage. As a Nurse Practitioner Lesley participates in a chronic disease outreach team program working with a multidisciplinary team of chronic disease nurses, Aboriginal health workers, GPs, and a nephrologist, who visit an Aboriginal Medical Service to provide care to community members living with chronic kidney disease.[7]

The current healthcare system works well for those who are able to privately fund the total cost of their care and therefore receive a package of privatised services that are usually provided by a network of established reciprocal provider pathways. This system is generally navigated by well informed empowered individuals who have the skills necessary to make informed decisions and to interpret options with a degree of insight.

The system falls short for people living with chronic and complex health conditions who rely on co-funding for services and who may have to navigate the health systems to piece together a health care package that firstly, might meet their care needs and secondly, which they can afford. This option provides additional challenges for those people who lack capacity due to their mental health, and those who are socially or culturally disadvantaged.

It is also worth noting that there is a lack of clarity as to the public health functions of individual primary healthcare providers and a lack of a coordinated approach to information gathering and establishment of community wide preventative health program and health promotion. There exists a postcode lottery of such programs which will present major challenges in terms of the funding and coordination of care for people with chronic and complex health conditions in the future.

[7] Rural Doctors Network Annual Report 2012-2013. Durri AMS, Proactive abstract. Kidney Disease, p. 67.

What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

The ANMF considers the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions is created by the funding mechanisms. The focus is on general practice instead of the central focus being on the person requiring care and where services can best be situated to meet care needs. The public/private sector mix, the jigsaw puzzle of funding mechanisms, and funding barriers for some sectors of the workforce, such as Nurse practitioners and other registered nurses and midwives, means these health professionals are underutilised in the primary health care sector. When the full range of health professionals is not used within primary health care, this decreases choice for consumers of the services and more importantly decreases their access to care.

Where health professionals work in teams, there is, as mentioned above, effective service delivery with better outcomes for the community in chronic disease management. Where there is no, or fractured, communication between health professionals, information and service delivery gaps occur, to the detriment of the care recipients.

An additional gap in primary health care relates to initiatives aimed at educating the general public to consider their future health care needs as they age. This education would be designed to encourage the public, especially people with chronic and complex conditions, to engage in discussions with their families and their general practitioners regarding advance health directives and enduring powers of attorney for health matters. These directives and powers assist to smooth a person's journey through the healthcare and/or aged care systems, particularly when their health condition impacts upon legal capacity, at a time when family members and health practitioners alike need direction on how to proceed with the person's healthcare.

Theme 1 - Effective and Appropriate Patient Care

Questions on Patient care

Do you support patient enrolment with a health care home for people with chronic and complex health conditions?

What are the key aspects of effective coordinated patient care?

Do you support patient enrolment with a health care home for people with chronic and complex health conditions?

The ANMF sees some merit in the suggestion of enrolment with a 'health care home' for people with chronic and complex conditions (including people with a disability or a long-term mental illness), in terms of accountability for government funding and health outcomes. However, we are concerned about the potential for cherry picking of patients by health professionals, and of limitations to choice by care recipients. There is the potential for private health providers to 'cream off' the most profitable elements within care pathways and neglect the longer term preventative services and data collection functions aligned to preventative/public health strategies.

On a positive note, it is pleasing to see the term used is 'health care home' and not 'medical home' as has been mooted in times past. In our view, should there be a 'health care home', this should not come with a requirement for funding to be a tied to a general practitioner. The 'health care home' concept is a broader and more inclusive term, allowing for a range of health professionals. We consider this model gives the opportunity for making a broader range of primary health care services more accessible and enables choice for the care recipient. It encourages and allows for care provision by nurse practitioners, other registered nurses and midwives, general practitioners and other health practitioners, so that individual needs can be met. This would move services away from the absurd and universally frustrating model of 'six minute medicine'.

A 'health care home' must reflect what the individual needs for their chronic or complex care. That is, we want to empower the individual to seek what works for them. The 'health care home' could be a practice in the broader sense of the word,

therefore a practice including nurses, nurse practitioners, midwives, general practitioners, Aboriginal and Torres Strait Islander health practitioners and allied health. The 'health care home' concept as described facilitates greater flexibility of location, such that the person may go to the 'health care home' or the 'health care home' comes to them.

Our rationale for opening up the 'health care home' beyond the general practice environment is also to accommodate the many marginalised people who don't use mainstream health services. This includes homeless people, itinerate workers and other mobile people (such as the 'grey nomads') for whom a designated 'health care home' doesn't work; but also people for whom the general practice option is not accessible either due to geography or affordability.

An example of where the 'health care home' does work, and for the whole community and not just the individual, is with Aboriginal Community Controlled Health Organisations. These organisations actually advocate on behalf of their clientele population, with regard to chronic disease prevention and intervention funding and strategies, as well as chronic and complex conditions management. Their model of community engagement is one worthy of replication in the broader community.

What are the key aspects of effective coordinated patient care?

As previously stated, the ANMF maintains the registered nurse is the ideal health professional to undertake the care co-ordination role in primary health care. This is due to their breadth of knowledge, skills and clinical judgement; their predominance across the primary health care sector; their proven track record in undertaking this role across the entire health care system; their connectedness with other health professionals and service resources in the healthcare sector and broader community; their philosophical base of holistic care (consideration of physical, mental, socio-economic, cultural, spiritual factors); and, ability to prioritise service and treatment regimes. The care co-ordination role traditionally undertaken by nurses in the tertiary sector easily transfers into general practice and primary health care more broadly.

The ANMF considers key aspects of effective co-ordinated patient care are:

- a focus on the care co-ordination and best care outcome for the individual;
- for the registered nurse co-ordinating the care to have a good understanding of the person's clinical health needs;
- for the registered nurse co-ordinator to be aware of care options, especially affordability for the individual;
- a bridge between public and private services, where required;
- for there to be respect among clinicians for the expertise each contributes to the care; and,
- for the care to be driven by the individual's health needs and not on financial remuneration for the health professional.

While nurses have been at the forefront of primary health care, they are increasingly embracing leadership roles in the general practice environment. General practice has largely moved beyond the solo practitioner to include various other key and complementary roles including nurse practitioners and other registered nurses who co-ordinate care.

An example of multidisciplinary primary health care teams collaborating to co-ordinate care can be seen in clinics (often nurse-led) which create communities of wellness. These will include a range of health professionals such as nurses, exercise physiologists, occupational therapists, medical practitioners or dietitians. The emphasis is on healthy life-style promotion, and activities may involve walking groups, smoking cessation strategies, healthy eating and cooking classes, for example. The activities may also be centred on those with established disability from chronic and complex conditions, such as gentle exercise or swimming.

A specific example from Queensland is the 'patient navigator role' undertaken by nurses. In this patient-centred health care delivery model, the focus is to promote timely movement of an individual through an often complex health care continuum. This is particularly appropriate for people needing complex referral to a

multidisciplinary team and where ongoing management is required as for chronic conditions. Further information on this model can be found at Appendix C.

Registered nurses undertaking a primary health care role as care navigators for people with chronic and complex health conditions should be utilised to signpost people to services; using evidence based clinical care pathways and national benchmarking. Nurse practitioners and/or registered nurses and midwives are ideally placed to perform such functions and resources should be made available to ensure there are adequate numbers available for these roles.

Theme 2 - Increased use of Technology

Questions on Use of technology

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care?

What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

Before addressing the questions on technology it is important to stress that improvements are needed across all communication modalities between health professionals. Outcomes of care are too often compromised due to breakdown in communication between different sectors of the health and aged care systems. Improvements to communication by the use of technology will only be effective if there is a genuine desire and effort towards judicious, meaningful and respectful information sharing between health professionals and the person receiving care.

There is now an emphasis across the country on collaboration within multidisciplinary health care teams in the delivery of care. Notions of one health professional automatically being the ‘captain of the team’ are passé. Instead, within teams where there is mutual respect for the contribution of each to the care process, and roles may shift and change according to the specific health issues being addressed. With

collaboration comes the need to communicate effectively and in a timely manner, in the provision of safe and competent care.

The advances in technology referred to in the discussion paper do not obviate the need for better verbal and written communication channels. The foregoing commentary serves to highlight that communication is broader than just technology for information sharing across primary health care, and between primary health care and the tertiary/aged care sectors.

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care?

The ANMF has thrown its considerable weight behind supporting the introduction of e-Health technologies into the health and aged care sectors. Improvements in information transfer are critical to creating a seamless passage for people with chronic and complex conditions through the primary health care system. Ready access for all health professionals employed in primary health care to email, internet, records management systems, and patient history records systems, is essential for timely and safe health information management. Health care professionals require access to information in a timely manner and recipients of care need to know that these professionals have access to their information. This is particularly pertinent to people with lengthy and involved health histories, as constant repetition is tiring and frustrating, and creates potential for transfer of partial or incorrect information.

The ANMF is a strong supporter of the implementation of the individual electronic health record system to facilitate rapid transfer of information across facilities, and between primary, secondary and tertiary sectors. The electronic system also provides a greater degree of transparency of a person's' health records to all parties involved in that person's care – especially the person themselves. We should not lose sight of the fact that the information belongs to the person NOT the health professional! It is also important that all electronic health record systems, and all types of technology provides protection for the consumer in relation to their health information, and who

accesses this information, under the confidentiality and privacy laws in the Commonwealth, and each State and Territory.

Better provision of primary health care services through the use of technology such as access to telehealth services reduces the inconvenience of people with chronic and complex conditions needing to go to health care facilities for investigations or therapy. This especially applies to people living in rural or remote parts of the country, for whom travel may not only be painful, arduous and costly, but also difficult for family members or other carers who accompany them.

While supportive of technological advances, we must be mindful of the fact that not all members of society are able to access IT or use it effectively. Indeed there will always be a section of society who chooses not to use this platform to receive care or services, or to access information. For others, it is not choice but capability that determines this, such as mental illness or physical disability. Sectors within our society should not be further marginalised through implementation of technology.

What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

Enablers to support increased use of the technology to improve team based care for people with chronic and complex health conditions include:

- investment in the software and hardware required for expanding the use of the personal electronic health records system;
- funding incentives for health providers to engage with the personal electronic health record. Funding should be attached to the entry of episode of care.
- expediting implementation of the 'opt out' system for the personal electronic health records system (the new *myHealth* Record);
- education and support for the introduction of telehealth technology into the primary health care environment. This is both for the health care workforce and for the public and includes interpreting of data which may come in a different format via the internet;

- promotion of the Telehealth standards guidelines for nurses and midwives, as prepared by the ANMF led consortia[8]; and
- acknowledgement of the role of Nurse practitioners as consultants to a tele-health episode with amendments for appropriate remuneration for this role.

Nurse practitioners and eligible midwives are using electronic and other contemporary forms of telecommunications such as telehealth for providing advice, support and referral purposes. Telehealth is being used for people in rural and remote centres to improve access for people to specialists in their area of chronic disease. This approach to consultations gives convenience to people with chronic conditions, reduces the need for travel (which can be a painful process for the person with chronic conditions), is better for carers, and overcomes disadvantage due to geographical location of the person. The nurse practitioner and eligible midwife can participate in the telehealth consult and assist the care recipient as they gain access to specialist advice, treatment, monitoring and the most up to date evidence-based therapies. In addition, the nurse practitioner and eligible midwife can themselves be the specialist on the remote end of a telehealth consult with a person who is at their general practice or aged care facility.

Theme 3 - How do we know we are Achieving Outcomes?

Questions on evaluating system performance

Reflecting on Theme 3, is it important to measure and report patient health outcomes?

To what extent should patients be responsible for their own health outcomes?

Reflecting on Theme 3, is it important to measure and report patient health outcomes?

[8] Australian Nursing Federation. 2013. *Telehealth Standards for Registered Nurses*. Australian Nursing Federation. Australia.
Australian Nursing Federation. 2013. *Telehealth Standards for Midwives. Australian Nursing Federation.* Australia.
Australian Nursing Federation. 2013. *Guidelines for Telehealth On-line Video Consultation Funded Through Medicare.* Australian Nursing Federation. Australia.

Yes, we do need to attempt to do this. It provides evidence-based practice about primary health care and the way in which it can help to improve people's chronic health conditions.

The ANMF considers it is important to monitor services provided in terms of improved outcomes for the recipients of the care delivered, as should always be the case. Of prime importance is the consultation which needs to occur with the recipients of the care services and/or their carers, to ascertain what they would consider to be the most appropriate mechanisms for them to be able to participate in feedback to shape programs and service delivery.

There should always be a way to measure and report health outcomes to inform public health strategy and benchmarking. This should be undertaken at primary health care level but with oversight from an overarching public health body or function within each health district, with links to the Commonwealth.

With regard to measuring and reporting there should be an expectation that chronic disease management plans are measured to ensure they are making a difference to a person's health outcomes. It must be acknowledged, however, that there are impacting factors contributing to a person's health status over which the health professionals may have little control. These variables include (but are not limited to): health literacy; socio-economic status and especially poverty; level of empowerment to effect positive changes in one's health; degree of health deterioration from the chronic condition; and, impacts of social determinants of health such as housing and the physical and emotional environment. It is critical that outcome measures be determined in consultation with the individual.

To what extent should patients be responsible for their own health outcomes?

In many circumstances the individual may not have control over their health status. Many people have multiple chronic and complex conditions that do not have a known cause and a range of contributing factors, may impact on the disease progression.

All health professionals promote self-management strategies to people with chronic conditions in order to encourage them to take responsibility for their own health outcomes. It is not always reasonable or possible for the person, however, to have control over all aspects of their disease processes.

People with chronic and complex conditions may need to be educated and encouraged to accept personal responsibility for their health outcomes and lifestyle choices but not to report on them as compliance rates would be low and this would impact on data quality to inform policy. Data obtained from local level could inform national strategies and raise public awareness. Issues affecting particular areas could be identified for local targeted campaigns. Data collection at a local level would assist this.

Theme 4 - How do we establish suitable payment mechanisms to support a better Primary Health System?

Questions on Payment Models

How should primary health care payment models support a connected care system?

What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

How should primary health care payment models support a connected care system?

The current systems for health funding in Australia create serious barriers to effective health promotion and chronic disease management, and limit effectiveness in terms of equity, access and value for money in primary health care. In most instances, the community does not have much input or control in relation to health strategies that directly affect them. The models of promotion, prevention, chronic and complex condition care and treatment are not always based on the best available evidence. This leads to discrepancies in their efficiency and cost effectiveness. The current

care modalities do not necessarily provide for positive outcomes for people and their communities; and sustainable, replicable service delivery remains a challenge.

The ANMF strongly supports funding models which provide for positive health outcomes for communities through sound health policy designed to meet population needs. Funding for services, programs, care and treatment must be based on the health needs of the community and be designed to promote the goals of primary health care enabling the promotion of health, maintenance of health, and continuity of care for chronic and complex conditions management; and, funding must allow for the involvement of a range of health care professionals in the care. This model allows for a person to be seen by the right health professional for their needs, in an appropriate place, at the right time - that is, a ‘needs’ driven funding model, not one driven by a particular health care professional.

Providing a blended payment system (mixing fee-for-service, pre-payment and payment for performance with salaried arrangements) in primary health care, to facilitate team based care, is supported by the ANMF as a means to achieve an integrated model of care and optimal health outcomes. Furthermore, the ANMF maintains the key to providing better access for the community to primary health care services is the development of funding models in which the funding maximises services directly to the consumer (the funding follows the person) and not solely to the provider (as in the current fee-for-service model). This allows for nurses, midwives and other health professionals to engage more meaningfully in chronic disease management without the flawed arrangement of this funding being tied to the GP, who may only see the person briefly during an episode of care, if at all.

Nurses and midwives, as well as some other health professionals should have direct access to funding to cover all aspects of their primary health care practice without the process being 'for and on behalf of’ a third party.

We believe that nurse practitioners and eligible midwives should be used more extensively within multidisciplinary teams across the spectrum of primary health care

services, in all geographic locations. Nurse practitioners and eligible midwives can, and do, undertake important roles in providing improved access to primary health care services and chronic disease management, to individuals and communities. Consumers thus have access to a broader range of health professionals, and to those who are particularly skilled in, and have time, to deal with chronic and complex conditions.

In order to facilitate access to nurse practitioners a number of structures need to be put in place. There needs to be subsidised funding from the Australian Government for designated nurse practitioner positions in the public sector, especially in rural and remote communities; nurse practitioners in the public sector need to be given access to MBS to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals when required. That is, we request that nurse practitioners in the public sector be given 'request and refer' access to the MBS, just as is the case for medical interns. So too, there should be a substantial increase in the payment for MBS items for nurse practitioners in private primary health care settings, including mental health, to enable them to establish viable and sustainable practice. Nurse practitioners are established in Australia, and have already proven their value to our health and aged care systems. Accessibility to their range of care modalities, including chronic disease management, should be facilitated and broadened to better meet population health needs. Additionally, we are firmly of the view that the clinical leadership of such primary health care services should be provided by persons on their merit, knowledge, skills and experience rather than professional designation.

Examples of nurse practitioner or eligible midwife led primary health care clinics include: clinics to improve the health outcomes of Aboriginal and Torres Strait Islander peoples' mental health, and, chronic disease management – it is well documented that renal, respiratory, cardiac and endocrine chronic conditions are all more prevalent amongst Aboriginal and Torres Strait Islander peoples. In addition, the use of nurse practitioners in aged care settings, in residential aged care or the

community, is invaluable to maintaining the health of our elderly and preventing unnecessary hospitalisation, for issues arising from chronic conditions.

- The ANMF considers the following issues are essential for funding for nurse practitioners in the primary health care sector: funding for designated Nurse Practitioner positions in the public sector, including in small rural and remote communities
- access to 'request and refer' MBS provider numbers for Nurse Practitioners in the public sector, as is the case for medical interns
- a substantial increase in the payment for MBS items for Nurse Practitioners in private practice to enable them to establish viable and sustainable practice
- recurrent incentive funding for Nurse Practitioners in private practice to work in areas of designated District Workforce Shortage
- infrastructure funding for Nurse Practitioners to establish private practice
- allowing Nurse Practitioners to employ other nurses under the PNIP in the same way as GPs

The funding models for primary health care must not be developed in isolation. In relation to Primary Health Networks (PHNs), there is an absence of executed bilateral agreements regarding the respective roles and responsibilities of the Commonwealth and State/territory governments and the functions of PHNs within each State and Territory health system, which is problematic.

The operational budget for each PHNs will need to be adequately resourced to enable the PHN to deliver on the objectives set by the Government and meet the person-centred needs of the population. Therefore, the budget will require the flexibility and adjustment, informed by data on the health status of the population, and taking into account the need to invest in health promotion, and the specific nursing and midwifery services within the multidisciplinary team. In addition there must be acknowledgement that sometimes there will be competing population health needs, however, that should not prevent minority groups from accessing primary health care services.

What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

The ANMF does not support Private Health Insurance (PHI) having a role in managing people with chronic and complex health conditions in primary health care.

The care coordinator for the patient may in certain circumstances recommend a particular private health insurance service but this should be on the basis of access, cost and need not on a self-interest basis. They may support these people but should not be in a position to manage their care. The concern is that clinical decision making by clinicians could be usurped by the provider, that is, through managed care.

PHIs should not be the driver for services for chronic and complex health conditions – if this were the case then service delivery would be based on preparedness to pay rather than on clinical need of the individual. Apart from being morally wrong this approach would not necessarily meet the population health needs but rather serve the interests of some health professional groups. We maintain that payment for care should follow the person, not the provider.

Essentially, quality patient centred healthcare must continue to be the driver for healthcare services, supported by universal healthcare for all Australians.

Conclusion

The nursing and midwifery workforce is currently an under-utilised resource in the primary health care arena, especially in the management of people with chronic and complex conditions. This is due either to restrictions on scope of practice or lack of recognition of the role and function of nurses and midwives. The ANMF maintains there needs to be a much greater utilisation of the nursing and midwifery workforce in order to ensure appropriate services for all geographical areas and population groups. Nurses and midwives form the largest health care professional group across the primary health care sector and are well placed to play a greater role in chronic and complex care management.

The ANMF maintains the key to providing better access for the community to primary health care chronic disease management services is the development of funding models in which the funding follows the recipient of care and not the provider (as in the current fee-for-service model).

It is essential that the changes made to the primary health care are not more of the same of what we have, the changes need to enable innovation. With the increasing age of our population and increasing rates of chronic and complex disease we need to re-think the way primary health care is delivered. Nurses and midwives are key to this change. The system needs to provide the option for nurses and midwives to provide their intrinsic care which is delivered the way the individual and community wants and needs. Nurses and midwives clearly understand and address the social determinants of health and how this affects the health of individuals and their community. Nurses and midwives are best placed to be care coordinators with their philosophical approach to connect individuals to the right treatment or refer them to the right health professional when required.