Australian Nursing And Midwifery Federation

PRE-BUDGET SUBMISSION 2021-22

Australian
Nursing &
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Federation

INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) welcomes the opportunity to provide input to the 2021-22 Australian Government Budget.

The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight State and Territory branches, we represent the professional, industrial and political interests of over 300,000 nurses, midwives, and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

2020 was the World Health Organization (WHO)-appointed 'Year of the Nurse and Midwife'.[1] Perhaps at no other point in living memory have healthcare workers, including nurses and midwives, been so integral to global health. The ongoing COVID-19 pandemic thrust particularly health and aged care workers into the limelight and onto the frontlines of protecting and caring for the community and whole populations against the impact of a deadly and highly contagious illness. At the same time, health and aged care workers faced incredible hardships and personal danger at and beyond work in their heroic efforts to save lives and care for the sick.

[1] World Health Organization (WHO). Year of the Nurse and the Midwife [Internet]. WHO. 2020. Available online: https://www.who.int/news-room/campaigns/year-of-the-nurse-and-the-midwife-2020

Nurses and midwives play a fundamental role in providing health, aged care, maternity care, and mental health services across the full gamut of health care. Nurses, midwives, and carer workers, as the largest workforce in Australia devote their lives to caring for mothers and children; giving lifesaving immunisations and health advice; looking after older people and meeting essential and everyday physical and mental health needs. The COVID-19 pandemic is far from over, and while Australia has been largely spared the worst impacts still faced by other nations, our health and aged care workforce is working at their limit. The long-lasting impact that COVID-19 will have on Australian's health and well-being is complex and multi-faceted, with issues around such areas as mental ill health and domestic violence likely to persist for some time. Now is when the Australian Commonwealth must act and genuinely invest in the health, aged care, disability, maternity, and public and preventive health sectors as never before.

Our submission highlights the contribution nurses, midwives, and carers currently make to Australia's health and aged care sectors and outlines how, through good, well-funded Government policy, this contribution must be dramatically increased. Adopting and implementing our submission's recommended policy reforms would result in improved cost efficiency for Governments and providers, increased patient satisfaction, better health and wellbeing outcomes, and nurses and midwives being generally happier with the work they were doing resulting in better employment recruitment and retention. The 2021-22 Federal Government Budget is a major opportunity to break down barriers that prevent nurses and midwives from working to their full potential to protect and improve the health of all Australians, now and in the future.

Annie Butler
Federal Secretary

Lori-Anne Sharp
Assistant Federal Secretary

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NURSING AND MIDWIFERY WORKFORCE

Nursing, midwives, and carer workers represent Australia's largest workforce and make up over half of the overall healthcare workforce. Following 2020 – Year of The Nurse and The Midwife and due to the ongoing COVID-19 pandemic, the Federal Government must urgently invest in Australia's health and aged care workforce through effective, decisive action to give us the human and physical resources needed to both recover from the pandemic and ensure Australia sustains a world-leading health, maternity, and aged care system. In line with the 'Triple Impact Report', true universal health coverage cannot be achieved or maintained without strengthening nursing and midwifery. Not only do the number of nurses, midwives, and carers need to be increased, it is also crucial to making sure their contributions to health and wellbeing are properly understood and that policy and funding enables them to work to their full potential across all settings.[2] The ANMF agrees that strengthening nursing will have the triple impact of improving health, promoting gender equality and supporting economic growth.

Education and Training

1. The availability of a skilled and experienced workforce directly underpins the capacity of the health, aged care, and disability service sectors to deliver the level of care and support required now and in the future. Over the next five years, the Health Care and Social Assistance industries are projected to make the largest contributions to employment growth, with 252,600 new workers making up 15% of Australia's projected employment growth to May 2024.[3] The aging population and demand via the National Disability Insurance Scheme and aged care sector are key factors in this growth. This projected growth includes an additional 41,000 registered nurses and midwives, 3,000 enrolled and mothercraft nurses, and around 106,400 additional personal carers and assistants including aged and disabled carers.[4]

2. While these projections suggest that Australia needs to continue investing in the education of registered nurses, enrolled nurses, midwives, and carers, they do not indicate whether the increased employment rate will actually satisfy demand. As COVID-19 has shown us, without an adequately sized and skilled workforce, meeting the demands of rapid surges of patients along with the necessity to quarantine staff who may be exposed to infection is challenged. A larger pool of employed nurses would mitigate this risk in the future and ensure a sustainable and resilient health and aged care sector.

3. The Government needs to undertake robust workforce planning to ensure sustainable supply of sufficient numbers of nurses, midwives, and carers to meet Australia's future demand across health, aged care, maternity care, and disability service settings and across geographic regions.

[2] All-Party Parliamentary Group on Global Health. Triple Impact How developing nursing will improve health, promote gender equality and support economic growth [Internet]. London. October 17 2016. Available online: http://www.appg.globalhealth.org.uk/
[3] Australian Government Department of Employment, Skills, Small and Family Business. Industry Employment Projections 2019 Report [Internet]. 22 November 2019. Available online: http://lmip.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections
[4] Australian Government Department of Employment, Skills, Small and Family Business. Employment Outlook to May 2024 [Internet]. 22 November 2019. Available online: http://lmip.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections

4. The Commonwealth Government is yet to act on the 2019 national and independent review of nursing education. This comprehensive review found inconsistency between the number of graduating nursing students and the lack of jobs available for them.[5] This review noted the wealth of evidence demonstrating that Transition to Practice Programs are effective in reducing turnover and work stress and improve patient safety and job satisfaction.[6] Transition to Practice Programs are important to assist nurses transitioning from education to the workforce, but are highly competitive and not universally located. They should be available to all newly graduated nurses and midwives working in any setting or context.

5. The Government needs to ensure that newly graduated nurses and midwives are provided with meaningful employment opportunities across the health and aged care sectors, including into areas of increasing demand, such as mental health, preventive and primary health care, disability services, alcohol and other drugs, and aged care. Providing timely, effective support for the transition of new graduates into the workforce is critical to attracting and keeping them in the workforce and therefore building an experienced and supported nursing and midwifery workforce for the future.

6. Even prior to the COVID-19 pandemic, it was vital that Australia become better able to support effective attraction, transition, and retention of domestically trained nurses and midwives. Now during the pandemic and for the foreseeable future, it is important that Australia not rely on other nations to provide a suitably sized and sustainable health and aged care workforce. Many countries where large numbers of internationally qualified nurses travel from to work in Australia such as India and the Philippines desperately need to maintain the size and capacity of their own health workforces and as such it is unethical, damaging (and impractical during a time of widespread border closures) to rely on other countries to supply Australia with nurses and other health professionals when there is scope to increase the employment of domestically trained nurses and midwives.

7. The ANMF calls on the Government to:

i. Partner with State and Territory Governments and nursing and midwifery organisations and peak bodies including the ANMF to undertake workforce assessment and planning to ensure sufficient numbers of nurses and midwives to meet Australia's future demand.

ii. Undertake timely, accurate trend analysis of nursing and midwifery student numbers on enrolment, completion, and employment recruitment and retention rates to enable informed decision making.

iii. Partner with health and aged care, education and training providers, health and workforce researchers and nursing and midwifery peak bodies including the ANMF to enable improved recruitment and retention of the nursing, midwifery, and carer workforce.

iv. Increase employment opportunities for newly graduated and early career nurses and midwives by providing dedicated, sufficient, and sustainable funding and resources to implement appropriate graduate Transition to Practice Programs for all nurses and midwives regardless of setting, as well as in other areas of employment such as private hospitals, aged care, mental health, general practice, disability, and rural health services.

v. Promote the recruitment and retention of newly graduated and early career nurses and midwives within the workforce by ensuring graduate Transition to Practice Programs include adequate resourcing and clinical education to enable experienced registered nurses and midwives to provide appropriate support to early career nurses and midwives in their transition to practice.

[5] Schwartz S. Educating the Nurse of the Future - Report of the Independent Review into Nursing Education. Commonwealth of Australia [Internet]. 2019. Available online: https://www.health.gov.au/resources/publications/educating-the-nurse-of-the-future (accessed 5 Dec 2019).
[6] Schwartz S. Educating the Nurse of the Future - Report of the Independent Review into Nursing Education. Commonwealth of Australia [Internet]. 2019. Available online: https://www.health.gov.au/resources/publications/educating-the-nurse-of-the-future (accessed 5 Dec 2019).

Improving Workforce Utilisation

8. The Commonwealth Government does not adequately support health and aged care services and staff to provide models of care which may be more effective, appropriate, cost-effective, or preferred, despite a growing body of evidence demonstrating safety, clear benefits, and positive patient preferences.[7,8,9,10]

9. Australia has a skilled and highly qualified nursing and midwifery workforce which, while critical in determining national health outcomes, is largely under-utilised.[11] Nurses and midwives are still denied opportunities to realise their full potential and optimally contribute to the health, aged, maternity, disability, mental health, and primary health care sectors. The ANMF argues that current funding to and structures within these sectors restrict peoples' choices for both the type of clinician and model of care used to treat and/or manage their injuries, illnesses, and conditions. The COVID-19 pandemic has revealed these deficiencies even more starkly over the last year.

10. While the adoption of nurse- and midwife-led clinics around Australia is gradually improving, their inclusion in a broader national health, maternity, and aged care strategy is needed beyond simply where service gaps due to high demand and/or workforce shortages occur.

11. By undertaking appropriate workforce reform and expanding opportunities for an increased variety of proven models of care, particularly in aged care, maternity care, mental health, primary care, and transition care, better and more affordable services can be offered to more people over a greater diversity of regions and contexts. This would involve much better use nurse- and midwife-led clinics and models of care, mental health, and preventive and primary health care nurses, and nurse practitioners (NPs).

Nurse practitioners

12. An NP is a RN whose registration has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) under the Health Practitioner Regulation National Law 2009 (the National Law). The NP role is the most advanced clinical nursing role in Australia, with additional responsibilities for patient assessment, diagnosis and management, referral, medications prescribing, and the ordering and interpretation of diagnostic investigations.

13. Despite long-standing and substantial evidence demonstrating the benefits of NP-delivered care across many settings and contexts,[12,13,14,15] NPs continue to be under-utilised and poorly supported within the Australian health and aged care sectors. As of September 2020, there were 2,097 NPs practising around Australia, an increase of only 810 since September 2015.[16] This compares to over 290,000 NPs in the United States.[17] The growth rate in the number of NPs in Australia remains relatively slow; in 2014 the US had 60.22 NPs per 100,000 population while Australia only had 5 per 100,000.[18]

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[7] Chan RJ, Et al. Clinical and economic outcomes of nurse-led services in the ambulatory care setting: A systematic review. Int J Nurs Stud. 2018;May(81):61-80.

[8] Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women [internet]. Cochrane Database of Syt Revs. April 2016; Available online: https://doi.org/10.1002/14651858.CD004667.pub5

[9] Jefford M. Improving the Care of Adult Cancer Survivors. Asia Pac J *Oncol Nurs.* 2020;7(1):2-5.

[10] Gordon K, Gray CS, Dainty KN, deLacy J, Seto E. Nurse-Led Models of Care for Patients with Complex Chronic Conditions: A Scoping Review. Nurs Leadership.32(3):57-76.

[11] Schwartz S. Educating the Nurse of the Future - Report of the Independent Review into Nursing Education. Commonwealth of Australia [Internet]. 2019. Available online: https://www.health.gov.au/resources/publications/educating-the-nurse-of-the-future (accessed 5 Dec 2019).

[12] DesRoches C M, Gaudet J, Perloff J, Donelan K, Lezzoni L I, Buerhaus P. Using Medicare data to assess nurse practitioner–provided care. Nurs Outlook. 2013;61(6):400-7.

[13] Donald F, et al. A systematic review of the effectiveness of advanced practice nurses in long-term care. *JAN.* 2013;69(10):2148-61.

[14] Martinez-Gonzalez N A, et al. Substitution of physicians by nurses in primary care: a systematic review and meta-analysis [Internet]. *BMJ Health Serv Res.* 2014;14(214). Available online: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-214

[15] Gonzalez A, Delgado V, Buscemi C P. Wound Closure Rates: A Comparison Between Advanced Practice Registered Nurse and Primary Care Physician Treatment. J Nurs Pract. 2019;15(9):e-173-6.

[16] Nursing and Midwifery Board of Australia. Statistics: Nurse and Midwife Registration Data Table – September 2020 [Internet]. Available online: https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

[17] American Association of Nurse Practitioners. NP Fact Sheet [Internet]. August 2020. Available online: https://www.aanp.org/about/all-about-nps/np-fact-sheet

[18] Maier C, Barnes H, Aiken L H, Busse R. Descriptive, cross-country analysis of the nurse practitioner workforce in six countries: size, growth, physician substitution potential. *BMJ* Open. 2016;6(9):e011901.

14. In Australia, while there is a growing recognition of the importance of NPs, meaningful inclusion of NPs in health and aged care workforce planning has yet to occur.[19] Barriers such as very limited access to the Medicare Benefits Schedule (MBS) and inadequate funding arrangements impede full utilisation of NP roles and prohibit many NPs from working to their full scope of practice to and deliver the greatest possible benefit to the wider community.[20] A 2016 study conducted in Australia with privately practicing nurse practitioners argued that mandating collaborative arrangements through legislation creates barriers to establishing private practice services which potentially inhibits consumer access to care.[21] A 2018 cost-benefit analysis commissioned by the Department of Health found that enabling patients to access Medicare rebates for care provided by NPs would improve access and deliver substantial savings to the health care system.[22]

15. Other important findings included cost benefit assessment evidence that;
    - The expansion of ten NP roles in aged care would cost approximately $AUD 1.5 million per year, but conservatively result in 5,000 avoided emergency department (ED) visits each year, and annual savings of over $AUD 5.7 million in reduced ED, hospitalisation, and ambulance costs.
    - The expansion of ten NP roles in rural and regional Australia, at $AUD 1.5 million per year, could conservatively improve access to care for 10,000 Australians.
    - Another 10 primary care NP roles across specifically targeted locations could provide services to over 6,000 Aboriginal and Torres Strait Islander population with limited access.

16. The barriers to optimising the potential contributions of NPs results in wasted opportunities for better health and wellbeing outcomes for many, and especially the most vulnerable people in Australia. They also contribute to increases in health and aged care costs due to unnecessary duplication. The ANMF argues that the barriers to the employment and full utilisation of NP roles must be removed and that the number of NPs in Australia must be significantly increased.

17. Not all qualified NPs are actually employed in NP roles or practising to the full scope of their role due to a range of barriers. Some of the restrictions on NP practice are:
    - the lack of positions;
    - the lack of viable employment opportunities in private practice;
    - inability to claim after-hours MBS item numbers when providing services;
    - restrictions on ordering of pathology and diagnostic tests and in particular, imaging;
    - the inability for people to receive certain subsidised medicines if prescribed by a NP (as distinct from a medical practitioner);
    - restriction to PBS prescribing for continuing therapy only for many PBS medicines; and
    - inadequate rebates from the MBS for NP services.

[19] Maier C, Batenburg R, Birch S, Zander B, Elliott R, Busse R. Health workforce planning: which countries include nurse practitioners and physician assistants and to what effect? *Health Policy.* 2018;122(10):1085-92.
[20] Australian Government Department of Health. Cost Benefit Analysis of Nurse Practitioner Models of Care [Internet]. A KPMG report commissioned by The Australian Government Department of Health. November 2018. Available online: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cost-ben-anal-npmoc
[21] Currie J, Chiarella M, Buckley T. Collaborative arrangements and privately practising nurse practitioners in Australia: results from a national survey. *Aust Health Rev.* 2016;41:533-40.
[22] Australian Government Department of Health. Cost Benefit Analysis of Nurse Practitioner Models of Care [Internet]. A KPMG report commissioned by The Australian Government Department of Health. November 2018. Available online: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cost-ben-anal-npmoc.

18. These factors severely restrict NP practice and reduce patients' access to safe and affordable care. To facilitate access to NPs a number of structures need to be put in place. Primarily, NPs in the public sector need to be given greater access to the MBS to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals including allied health, when required. That is, NPs in the public sector should be given 'request and refer' access to the MBS, just as is the case for medical interns.

19. The ANMF strongly endorses the recommendations made by the MBS Review Taskforce Nurse Practitioner and Participating Midwife's Reference Groups and has provided extensive comments to both groups.[23],[24] There should also be a substantial increase in the payment for MBS items for NPs in private primary health care settings, including mental health, to enable them to establish viable and sustainable practices.

20. The ability for NPs in primary health care to work to their full scope of practice is vital. NPs need to be recognised primary health care professionals, able to provide independent services under appropriately remunerated MBS item numbers. This will be a substantial opportunity for benefit during and following COVID-19.

Midwives with scheduled medicines endorsement

21. There are 647 midwives with scheduled medicines endorsement (MBS eligible midwives) in Australia.[25] The role of midwife with scheduled medicines endorsement is differentiated from other midwives by their expert practice in the provision of pregnancy, labour, birth, and post-natal care, across the continuum of midwifery care.[26]

22. Similar to NPs, midwives also face barriers to practising to their full scope, again limiting their practice and reducing women's access to affordable, high quality health care. These barriers are mirrored across the two professions with midwives in private practice facing additional obstacles in obtaining professional indemnity insurance to cover the full scope of their practice.

23. Midwives in private practice have access to only one professional indemnity insurance scheme: Commonwealth-subsidised professional indemnity insurance through MIGA (Medical Insurance Group Australia) which covers antenatal and postnatal care, and birth services the midwife provides in hospital to their private clients.

24. Midwives with scheduled medicines endorsement may also encounter difficulties in establishing legislated collaborative arrangements with medical colleagues required to engage in private practice, thus forming another barrier to practising to their full scope. Collaboration between midwives and other health and medical care staff is a fundamental element of the NMBA's Midwife standards for practice (see Standard 2: Engages in professional relationships and respectful partnerships).[27]

25. As collaboration is already embedded in the way that midwives practice, mandating collaborative arrangements appears redundant and counterproductive. Midwives are regulated, qualified health professionals and as such are responsible at law for the extent and scope of their practice, undertake risk mitigation for their own practice, and are required to have professional indemnity insurance as a requirement of their registration. Health professional colleagues, including medical practitioners, do not carry responsibility for the practice of a midwife.

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[23] Australian Nursing and Midwifery Federation. ANMF Response to the Department of Health Primary Care Reference Groups Consultation: Medicare Benefits Schedule (MBS) Review Taskforce Report from the Nurse Practitioner Reference Group [Internet]. June 7 2019. Available online: http://anmf.org.au/documents/submissions/MBS_Review_Taskforce_Report_Nurse_Practitioner_Reference_Group.pdf

[24] Australian Nursing and Midwifery Federation. ANMF Response to the Department of Health Primary Care Reference Groups Consultation: Medicare Benefits Schedule (MBS) Review Taskforce Report from the Participating Midwife Reference Group [Internet]. June 7 2019. Available online: http://anmf.org.au/documents/submissions/MBS_Review_Taskforce_Report_Participating_Midwife_Reference_Group.pdf

[25] Nursing and Midwifery Board of Australia. Statistics: Nurse and Midwife Registration Data Table – September 2020 [Internet]. Nursing and Midwifery Board of Australia. September 2020. Available online: https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

[26] Nursing and Midwifery Board of Australia. Endorsements and Notations: Midwife – prescribe scheduled medicines [Internet]. Nursing and Midwifery Board of Australia January 1 2017. Available online: https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations.aspx#eligible

[27] Nursing and Midwifery Board of Australia. Midwife standards for practice [Internet]. Nursing and Midwifery Board of Australia. October 2018. Available online: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx

26. The ANMF know that midwives want genuine collaboration, while also working autonomously within a team, so removing this requirement will not reduce their willingness to confer with their cross-disciplinary colleagues. Removing this provision will, however, contribute to a health care system that is able to capitalise on midwives' full potential, while also creating an environment that facilitates mutually beneficial, genuine cross-disciplinary consultation, collaboration, and mentorship. Making this change will result in safer, better, and more integrated maternity care.

Medicare Benefits Schedule

27. The overall objective of the Australian health system is that people have access to affordable, high-quality health care. This must be supported by ensuring that the Medicare Benefits Schedule (MBS) is consistent with the best available evidence and practice knowledge. Transparency and consultancy with relevant stakeholder groups (i.e. Clinical Committees) including medical professionals, NPs, and midwives with scheduled medicines endorsement, in the way that the MBS is reviewed is essential to ensuring that the system is fit for purpose for the provision of safe, optimal, patient care. To improve access to affordable evidence-based care for all members of the Australian community the MBS must continue to accommodate NPs and eligible midwives effectively.

28. The ANMF calls on the Government to:

i. Accept and implement the 14 recommendations made by the Nurse Practitioner Reference Group in their final report to the MBS Review Taskforce.

ii. Fund designated salaried positions for NPs and midwives with scheduled medicine endorsement in the public sector, including in small rural and remote communities.

iii. Enable nurse practitioners in the public sector access to MBS and a 'request and refer' MBS provider number to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals including allied health, when required.

iv. Provide funding for the expansion of NP roles, nurse-led, and midwife-led clinics in health, aged care, maternity care, mental health, and primary care.

v. Fund designated salaried NP positions in each Primary Health Network to support residential aged care facilities in providing quality care and reduce ED presentations and hospital admissions.

vi. Allow NPs with an MBS provider number to also be eligible for WIP practice stream funding.

vii. Provide recurrent incentive funding for NPs and midwives in private practice to work in areas of designated District Workforce Shortage.

viii. Provide infrastructure funding for NPs and midwives to establish private practice.

ix. Allow nurse practitioners to employ other nurses under the WIP practice stream in the same way as GPs.

AGED CARE

The Commonwealth Budget 2021-2022 must include significant and genuine investment into Australia's systemically flawed aged care sector. The title of the Royal Commission's 2019 Interim Report on Aged Care Quality and Safety – "Neglect" sadly still encapsulates aged care in Australia.[28] Unfortunately, due to ongoing lack of genuine Commonwealth Government investment, regulation, and responsibility, aged care in Australia is a story of woeful and increasing neglect further amplified by the past year of the COVID-19 pandemic and the Government's decision to delay real action until the release of the Royal Commission's final report on February 26 of this year. Australia's aged care sector is indisputably understaffed and the workers who are there are in many cases doing the best they can with little support, few resources, and limited recognition by providers and more broadly within the public domain. Many aged care providers need to increase their staffing levels and skills mix to deliver safe quality care for vulnerable residents and clients. Higher levels of staffing and better skills mix with greater numbers of registered nurses and enrolled nurses would provide better infection prevention and control and health care as well as greater support to nurses, care workers, and other staff. Workloads in aged care - often unmanageable prior to 2020 - have been intensified by the COVID-19 pandemic across the sector.

29. Even before COVID-19, hundreds of older people in aged care have died from potentially preventable causes such as falls, choking, and suicide. The COVID-19 pandemic has also starkly highlighted widespread problems in aged care that pre-existed but were magnified by the crisis. This Budget must contain genuine and sustained investment to fix Australia's aged care sector now. Many older people in aged care, especially those with complex, high care needs, are left unfed, unwashed, and alone for hours. Hard-pressed nurses and care staff do the best they can in impossible circumstances, but they are run off their feet, understaffed, and can't provide the safe, effective, dignified, and respectful care they want to, and that older people deserve. While our older people suffer and nurses and care staff struggle because there is simply too few of them. Staffing numbers, depleted even further by COVID-19 isolation measures, are dropping and many owners of aged care facilities profit while cutting staff and increasing workloads and reducing the quality and safety of working conditions for those who remain.

30. On February 26, 2021 the Royal Commission into Aged Care Quality and Safety will deliver its Final Report. To date, the Commonwealth Government has refrained from acting on many calls to urgently address the systemic problems in Australia's aged care sector citing an intention to await this final report. Soon, this excuse will no longer apply, and the Government will be looked to for action.

[28] Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

31. Older Australians deserve safe, quality aged care that is also affordable, accessible, and provided in a way that meets their diverse and unique needs for person-centred care. The 'shocking tale of neglect' described by the Royal Commission into Aged Care Quality and Safety:

    '[F]ound that the aged care system fails to meet the needs of our older, often very vulnerable citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them, in too many instances, it simply neglects them.'[29 (pp.5)]

32. Australia's aged care system has failed older people, younger people in aged care, families, and staff and has been described by the Royal Commission, as where aged care providers and staff who succeed in the provision of safe, effective, and appropriate care are only doing so 'despite the aged care system in which they operate rather than because of it.' '[30 (pp.9)] The ANMF agrees with the Royal Commission that there is a need

    '[F]or a fundamental overhaul of the design, objective, regulation, and funding of aged care in Australia'. [31 (pp.3)]

33. The ANMF highlights that successive Governments have commissioned a range of reviews of Australia's aged care system, but that action and reform to address the underlying issues that generate the need for such reviews have been slow to occur and have often been ineffective.[32] Clearly, aged care services and the people that access them have not been seen as a priority for successive Governments and the ANMF argues that this must change.

34. The ANMF has argued that the instances of inadequate and substandard care that have been exposed over the last year are not isolated, exceptional, or occasional, and have been amplified by the COVID-19 pandemic. The Royal Commission has heard that they are systemic, widespread, and even the norm. These systemic problems reflect significant flaws in the structure of the aged care system and the ability of the sector to respond to infectious disease outbreaks such as COVID-19, including: insufficient staffing levels and skills mix, inadequate coordination with local health services, inappropriate regulation of the sector; a lack of responsiveness to the changing needs of Australia's ageing population; a lack of transparency and accountability across the sector, and a lack of clinical governance at all levels.

35. There is now insurmountable evidence that inadequate numbers of qualified nursing staff lead to an increased risk of negative outcomes for those in their care. The ANMF highlights that chronic understaffing is a key contributor to the increasing number of instances of substandard care in Australia's aged care sector and the failure of infection prevention and control where outbreaks occurred in residential aged care.[33,34] The Royal Commission has stated that:

    'The quality of care that people receive from aged care services depends very much on the quality of the paid carers and their working conditions. Workforce issues are relevant to every aspect of our inquiry.' [35 (pp. 232)]

[29] Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx
[30] Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx (pp. 9)
[31] Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx (pp. 3)
[32] Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx (pp. 79-81)
[33] Gilbert L, Lily A. 2020. Independent Review Newmarch House COVID-19 Outbreak [Final Report]. Commonwealth of Australia, Canberra. Available online: https://www.health.gov.au/resources/publications/coronavirus-covid-19-newmarch-house-covid-19-outbreak-independent-review
[34] Gilbert L, Lily A. 2020. Independent Review of COVID-19 outbreaks at St Basil's and Epping Gardens aged care facilities [Final Report]. Commonwealth of Australia, Canberra. Available online: https://www.health.gov.au/resources/publications/coronavirus-covid-19-newmarch-house-covid-19-outbreak-independent-review
[35] Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx (pp.232)

36. The existing consistent and irrefutable evidence that staffing is inadequate in the Australian aged care sector is borne out by findings that the average rating of an Australian residential aged care facility is only two- stars for staffing (as calculated by the United States' Nursing Home Compare Rating System).[36] Further, on average, an Australian resident receives 36 minutes of care from a registered nurse per day - corresponding to a one-star rating. This fact is even more disturbing, considering that based on the ANMF's Staffing and Skills Mix study, a rating of less than five-stars according to this rating system would not provide safe, effective care for residents.[37]

37. Despite the apparent and widespread problems in aged care revealed before and throughout the Royal Commission, the COVID-19 pandemic, and voiced by our members in the 2019 National Aged Care Survey,[38] and COVID-19 survey,[39] aged care providers continue to reduce the number of nurses working in the sector.[40] This is despite a steadily increasing number of people entering the aged care system, many with complex needs that require care from qualified nurses and well-trained care workers in both residential facilities and homes in the community.

38. The ANMF has submitted extensive evidence to the Royal Commission including work commissioned by the ANMF in 2016 which provides an evidence-based methodology taking into account the amount of time staff require for the provision of direct and indirect nursing and personal care tasks and assessments of residents.[41]

39. This baseline for staffing requirements to underpin safe, quality care in RACFs is supplemented by a cost-benefit analysis (CBA) commissioned by the ANMF and undertaken by Flinders University.[42] This CBA suggests that full implementation of the recommendations of the staffing and skills mix report would be benefit cost neutral.

40. An additional implementation plan has also been developed by the ANMF to guide Governments on how safe staffing in residential aged care can be achieved. The plan outlines the care levels that are required by people in the sector, the impact of mandating minimum staffing levels and skills mix, and describes the stages of work required to 2025.[43]

41. The ANMF argues that that mandated minimum staffing levels and skills mix would be effective and amendable to inclusion alongside new technologies that enhance both care safety and quality as well as the experience and wellbeing of people within aged care. Further, had minimum staffing levels and skills mixes been mandated and implemented prior to the COVID-19 pandemic, Australia's aged care sector would have without question been significantly better able to deal with the ensuing crisis in terms of lack of sufficient staff to cope with the impacts of isolation and quarantine on both staff and residents. Had the Government acted sooner on recommendations from the ANMF and a range of experts and peak bodies such as those put to the Prime Minister in 2018 in our Joint Letter with the Australian Medical Association, the Royal Australian College of General Practitioners, and the Australian and New Zealand Society for Geriatric Medicine,[44] lives would have been saved and thousands spared from the neglect experienced daily in residential care before and during COVID-19.

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[36] Eagar K, Westera A, Snoek M, Kobel C, toggle C and Gordon R. How Australian residential aged care staffing levels compare with international and national benchmarks [Internet]. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf

[37] Willis E, et al. Meeting residents' care needs: A study of the requirement for nursing and personal care staff [Internet]. Australian Nursing and Midwifery Federation. 2016. Available online: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

[38] Australian Nursing and Midwifery Federation (2019). ANMF National Aged Care Survey 2019 – Final Report [Internet]. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria. Available online: http://anmf.org.au/documents/reports/ANMF_Aged_Care_Survey_Report_2019.pdf

[39] Australian Nursing and Midwifery Federation (2020). National COVID-19 in Aged Care Survey 2020– Final Report [Internet]. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria. Available online: https://anmf.org.au/pages/anmf-reports

[40] Eagar K, Westera A, Snoek M, Kobel C, toggle C and Gordon R. How Australian residential aged care staffing levels compare with international and national benchmarks [Internet]. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. 2019. Available online: https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf (pp. 5-6)

[41] Willis E, et al. Meeting residents' care needs: A study of the requirement for nursing and personal care staff [Internet]. Australian Nursing and Midwifery Federation. 2016. Available online: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

[42] Burgan B, Spoehr J, Moretti C. 2017. Financial and Cost Benefit Implications of the Recommendations of the National Aged Care Staffing and Skills Mix Final Report [Internet]. Adelaide: Australian Industrial Transformation Institute, Flinders University of South Australia. Available online: http://anmf.org.au/documents/reports/ANMF_CBA_Modelling_Final_Report.pdf

[43] Australian Nursing Midwifery Federation. 2019. Aged Care Ratios Make Economic Sense [Internet]. Australian Nursing and Midwifery Federation. Available online: http://anmf.org.au/documents/reports/Aged_Care_Ratios_Make_Economic_Sense.pdf

[44] Australian Nursing and Midwifery Federation, Australian Medical Association, the Royal Australian College of General Practitioners, and the Australian and New Zealand Society for Geriatric Medicine. 2018. Joint Letter to the Prime Minster of Australia the Hon Scott Morrison MP. Available online: https://anmf.org.au/images/uploads/Joint_Letter_To_ScottMorrison.jpg

42. The ANMF considers that overall, the aged care sector was unprepared/ill-prepared to meet the needs of operating within a pandemic environment. All the long standing aged care issues identified by the ANMF and numerous inquiries have degraded the capacity of the sector to rapidly and comprehensively respond to the pandemic risks. This pandemic appears to have been a stressor that has further broken an already damaged system. For example in terms of pandemic preparation long standing staffing and skill-mix issues have hampered developing a surge workforce and delivery of the increased clinical care that would be required for a facility outbreak. Lack of pandemic preparation should have also taken place on the basis of a "when" not "if" approach. This has resulted in lack of protective equipment and training at the coalface, supply chain issues and inadequate "stand up" processes to effectively manage such as situation (as appears to have been the case with the Newmarch House outbreak in Sydney).[45]

43. The ANMF highlights it is in aged care where shortfalls in the response to COVID-19 have been most stark and where lessons for future management can be learned. The ANMF considers that the Government could have improved its efforts to listen to and involve health experts, unions, and staff to respond more effectively to the pandemic in the aged care sector. The ANMF notes that unfortunately - aged care, particularly residential aged care - the area where people are most vulnerable to infection, illness, and death appears to have suffered from a lack of clear, consistent information regarding how best to respond to outbreaks as well as a lack of clear leadership and delegation of responsibility for ensuring the health and safety of older Australians, younger residents, and staff. Better preparation for not only pandemics, but localised outbreaks of infectious diseases is urgently necessary and should be funded by Government.

44. As well as addressing the often abysmally inadequate staffing and skills mix in residential aged care, the ANMF recommends that other actions must also be taken to support and sustain the delivery of safe, quality aged care. This includes but is not limited to improved education, training, and regulation of staff, an improved, transparent, and fit-for-purpose funding model, and an accessible and understandable system for ensuring that consumers are informed regarding the quality of care and staffing delivered by aged care providers. However, safe, quality care will not be achieved without mandating evidence-based minimum staffing levels and skills mix.

45. As the Australian population ages and their complex chronic health conditions increase, the need for medical care and care from other specialist health professionals, particularly NPs, palliative care specialists, and geriatricians will also increase. The Government must ensure that funding and regulatory structures which guarantee access to this care for older Australians are in place.

46. The ANMF supports policy initiatives that are focussed upon enabling older people to remain in their own homes for as long as possible. Indeed, more and more Australians wish to remain in their homes as they age. However, despite previously announced funding and place increases the current system and delivery of home care packages is not effectively supporting older Australians well enough and does not ensure that people are readily able to access the care they want and need when they need it.[46] This must be urgently addressed by the Government through better funding of home care packages, streamlining more efficient access to these packages, and improved support for the workforce that provides this care.

[45] Gilbert L, Lily A. 2020. Independent Review Newmarch House COVID-19 Outbreak [Final Report]. Commonwealth of Australia, Canberra. Available online: https://www.health.gov.au/resources/publications/coronavirus-covid-19-newmarch-house-covid-19-outbreak-independent-review

[46] Australian Government Productivity Commission. Report on Government Services 2020 Part F, Section 14: Aged Care Services [Internet]. Australian Government. 23 January 2020. Available online: https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/community-services/aged-care-services

47. The ANMF submits that both the Government and providers must be required to be transparent and accountable in relation to direct care funding. Aged care providers are not currently transparent regarding the staffing and skills mix of their facilities, or on how much they spend on other resources related to direct care provision, e.g. continence aids, medical equipment and supplies, and even nutrition. Yet, the public has a right to know that tax-payer provided subsidies to the sector are being directed to quality care provision. Too often we have seen Government initiatives intended to improve funding for wages in the sector allocated without any discernible benefit to workers in aged care, nor any accountability for how those allocated funds have been expended. The ANMF submits that to address this the Government must also be required to be more transparent as to the allocation of funds, identifying where the funds are directed, in particular funds allocated to provide direct care services. Providers at both the provider and site level must then be required to report how allocated funds have been acquitted. Transparency in funding will serve as an important measure for the public, consumers of residential aged care services, their families, the workforce and their representatives to have confidence in how tax-payer funded money is spent in the sector.

48. The ANMF argues that to enhance the aged care workforce's capacity and capability to provide high quality care, support good quality of life to care recipients, and make the aged care sector a more attractive and rewarding place to work the following must occur as a matter of urgency. Those that live and work in Australia's aged care sector cannot wait any longer for real Government action and investment.

49. The ANMF urgently calls on the Government to:

i. Introduce legislative change that ensures mandatory minimum staffing levels and skills mix in residential aged care in accordance with the ANMF's evidence, i.e. a national average of 4.3 hours of care per resident per day with a skills mix of 30% RNs/20% ENs/50% carers.

ii. Mandate that nursing homes must ensure the provision of at least 54 minutes of RN care per day to each resident included within at least 180 total minutes of care provided by RNs, ENs, and carers.

iii. Commit to full implementation of the above mandated staffing and skill mix model for residential aged care by 2025 (in accordance with the ANMF's implementation plan).[47]

iv. Commit to supporting a publicly available audit of current staffing levels in RACFs to determine current baselines and publish ongoing up to date information regarding staffing levels and skills mix in all facilities.

v. Determine and fund (as required) staged staffing increases required in RACFs commencing 1 July 2021.

vi. Legislate requirements for providers to enhance and improve clinical governance, leadership, and expertise at all levels.

vii. Legislate transparency and accountability measures for funding received by aged care providers where any allocation of additional funds to aged care providers must come with a clear mandate of accountability and transparency and that all funding provided for the purposes of direct care is the subject of accountability and acquittal arrangements such as if funds specified and allocated for care are not applied they are surrendered. To assist this funding must be linked to quality of care outcomes and determined through an evidence-based methodology.

viii. Funding for wage costs must be demonstrated to have been used for that purpose and a failure to account for the use of tax-payer funds must have consequences. For example, any funds allocated to direct care not spent should be returned to government or deducted from the next round of funding. In addition, funding available for wages and conditions must be made clear to the bargaining parties during enterprise bargaining.

ix. Establish an independent assessment body, which assesses and fixes funding by reference to independently assessed resident need.

[47] Australian Nursing and Midwifery Federation. Aged Care Ratios Make Economic Sense [Internet]. Australian Nursing and Midwifery Federation. 2019. Available online: http://anmf.org.au/documents/reports/Aged_Care_Ratios_Make_Economic_Sense.pdf

x. Agree to explicit accountabilities around public reporting of data, funding and aged care outcomes.

xi. Support the regulation of currently unregulated aged care workforce staff to ensure adherence to minimum education and training standards and ongoing adherence to safety and quality standards.

xii. Commit to wage improvement for aged care workers; wage outcomes for aged care workers must be improved to match public sector wages. This would involve an approximate 10-15 percent wage increase for all aged care workers to assist with recruitment and retention of quality workers.

xiii. Promote, fund, and sustain evidence-based safe work practices.

xiv. Establish an appropriate education and training framework to support the development of skills and workforce numbers needed to achieve minimum staffing requirements, in collaboration with the Aged Services Industry Reference Committee.

xv. Provide funding to educate nurses on their clinical leadership role in RACFs and home-based care and train carers in the assessment and management of the deteriorating resident. The ANMF is well placed to deliver this training.

xvi. Support and promote education pathways and transition to the workforce and career development in aged care through policy and funding.

xvii. Provide better funding support and incentives for specialist health professional in-reach services to be delivered on-site at RACFs, including incentives for GPs to attend those facilities.

xviii. Fund further home care packages, in particular Level 3 and 4 packages, to significantly reduce the increasing waiting list, while ensuring the allocation of available home care packages are appropriately triaged through clinical assessment by suitably qualified clinical professionals.

xix. Legislated, mandatory participation of residential and in-home aged care providers in the public reporting of contemporary, meaningful care safety and quality indicators.

xx. Fund sustainable implementation of evidence-based interventions and policy that ensures sector-wide preparedness for localised/isolated infectious disease outbreaks, epidemics, and pandemics.

xxi. Promote positive cultural perceptions of aging and elderly people and those who care for them.

xxii. Support and fund continual assessment of the Quality Indicator Program to ensure that it is capturing the data effectively and it is being used to improve the quality of care.

xxiii. Ensure that the Serious Incident Response Scheme is fit for purpose so that reported incidents must be investigated, analysed and appropriate measures put in place to minimise or eliminate the risk of further incidents.

xxiv. Fund the development of a reportable conduct scheme, with the Australia Quality and Safety Commission as regulator.

xxv. Ensure greater consistency of legislation governing the administration of medication across each state and territory, which creates inequity for aged care recipients in relation to the safeguards afforded to them. In addition, improve regulation of care workers with respect to medication administration or medication management.

xxvi. Fund the sustainable provision of restorative care and strength and mobility programs to be made available more widely to facilitate improvement in condition and improve quality of life.

xxvii. Fund programs to ensure specialist knowledge and skills in dementia and palliative care are embedded across the aged care workforce in order to improve the quality of care delivery across the aged care sector.

xxviii. Fund specialised services targeted at ensuring appropriate, effective care for members of diverse groups acknowledging diversity in meeting the personal care preferences and needs of individuals and communities to ensure safe, quality care.

PUBLIC AND PRIVATE HEALTH SECTORS

Australia's universal health care system and public and private health care sectors are some of the best in the world, but further investment and support is needed to ensure that all people achieve the best possible health and wellbeing outcomes, especially those that are most vulnerable. The urgency and scale of action in this space has been further emphasised by the COVID-19 pandemic and its widespread and long-lasting impacts on the health system and wider community. While many people can choose whether they want treatment in a public or a private hospital, the choice of hospital depends on a persons' condition, where they live, choice of healthcare provider, and whether someone is covered by private health insurance. The COVID-19 pandemic has revealed considerable access issues in the face of shut-downs. Underpinning the care provided in both public and private hospitals is the workforce, which is mostly made up of nurses, midwives, and carers.

50. The ANMF is committed to the provision of health as a public good with shared benefits and shared responsibilities. We consider that access to adequate health, maternity, mental health, disability care, and aged care is the right of every person and a crucial element of the Australian social compact.

51. Government investment in health is a growth and infrastructure investment that will pay dividends in the development of social capital and increased productivity for generations. Proper investment is therefore essential. The Federal Government's current spending of 10 percent of overall economic activity is not in line with comparable countries. In 2019, Australia ranked 11th in total health expenditure among the 36 OECD (Organisation for Economic Co-operation and Development) countries.[48] In the 2018–19 financial year, Australia spent $195.7 billion on health. In real terms, this represented a 3.1 percent real increase in spending over the year and is slightly lower than the decade average of 3.5 percent.[49]

52. The ANMF is steadfast in its support of Medicare as Australia's publicly funded universal health insurance, as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

[48] Australian Institute of Health and Welfare. Australia's health expenditure: an international comparison [Internet]. Australian Government. 7 June 2019. Available online: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-international-comparison/contents/table-of-contents

[49] Australian Institute of Health and Welfare. Health expenditure Australia 2017–18 [Internet]. Australian Government. 06 November 2020. Available online: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2018-19/contents/data-visualisation

53. While Australia's health system remains a world class health system and generally delivers good outcomes, too many inequalities persist. These inequalities are felt the hardest by the most vulnerable members of the population; Aboriginal and Torres Strait Islander Australians, people living in rural areas, culturally and linguistically diverse people including refugees and asylum seekers, gender and sexually diverse people, people who experience or are at risk of homelessness, and people who face socioeconomic disadvantage. These inequalities have likely been intensified by the impact of the COVID-19 pandemic on many facets of everyday life including healthcare and social services.

54. The lack of a genuine 'whole of system' approach to the delivery of health care across the country coupled with a lack of system coordination, and resulting fragmentation and duplication, means too many Australians cannot access the care they require when they need it and experience poorer health and well-being outcomes compared to other people simply because of who they are or where they live.

55. The ANMF recommends enabling increased flexibility in funding arrangements for public hospitals, the Pharmaceutical Benefits Scheme (PBS), the MBS, and aged care. Results would include the ability for regional health services to 'pool' some of these resources to meet the needs of their communities. For example, remote areas which are unable to recruit doctors could use the notional population share of the MBS to fund NP services for their communities.

56. Another key area that needs to be addressed across the sectors is the collection and management of health data, and performance reporting. It is disappointing that rates of complications by hospital, clinician, and procedure are collected by private insurance companies and State and Territory Governments but are not readily available. Due to this lack of transparency, patients and healthcare professionals lack the information they require to make informed treatment decisions and compare performance in order to learn from hospital sites with lower complication rates.

57. The ANMF calls on the Government to:

i. Establish an independent Health Performance Commission to be a specialist health data analytics and performance reporting body for both private and public health sectors responsible for: Mapping and co-ordinating the collection, analysis and publication of health data across the public, private and aged care sectors to enable value-based health care;

ii. Managing end-to-end data, working from collection to publication;

iii. Linking hospital and health data with other economic and social data as an evidence base for value-based health care and new health programs;

iv. Developing the quality of clinical performance indicators for outcome-focussed, value-based health care;

v. Undertaking further research to develop standardised, national nurse/midwife sensitive outcomes as important mechanisms for evaluating patient safety;

vi. Supporting viable and sustainable improvements in healthcare efficiency that reduce unnecessary care and waste without compromising optimal consumer outcomes and working conditions for staff.

vii. Improving access to clinical data by clinicians, boards, departmental, and HHS staff;

viii. Consulting with consumers and interest groups on the format, content, context and accessibility of publication of health care data;

ix. Evaluating new technologies, treatments and drugs;

x. Making research findings and raw data available to researchers where this has ethical approval and is in the public interest;

xi. Liaising with other States, Territories, and the Commonwealth to compare and share data, produce economies of scale and ease ongoing disagreements over funding;

xii. Ensuring compliance with mandatory public reporting requirements in the public and private sectors;

xiii. Legislated, mandatory participation of public and private and sectors in the public reporting of contemporary, meaningful patient/resident safety and quality indicators; and

xiv. Nurse/midwife participation in organisational governance and quality assurance as an essential mechanism for improving clinical outcomes through public reporting.

Value-based Healthcare

58. Outcome-focussed, value-based healthcare aims to provide the best care and outcomes possible for people who access healthcare services while most efficiently using the resources required to deliver that care. Value-based funding rewards and incentivises the achievement of better patient outcomes and well-being and puts people and attaining improved outcomes at the centre of care as opposed focussing on simply achieving activity targets.

59. The movement towards more widespread value-based healthcare is slowly occurring in Australia.[50,51] The ANMF urges the Federal Government to invest in the ongoing development, implementation, and uptake of value-based healthcare and funding models.[52]

60. The ANMF advocates for person-centred care in all care settings and argues that a movement toward the adoption of funding models that put people at the centre of their care is imperative. Value-based funding models involve delivering outcomes that matter to people and also considers the experiences of staff, those who require care, and their loved ones who many accompany them and who are impacted by contact with the health care sector.

61. Key drivers for moving towards a higher-performing health care system that is focussed upon delivering person-centred, value-based healthcare include:

    a. Collection, analysis, and use of patient- and patient-reported outcomes and associated costs.

    b. Up-to-date, accessible guidelines and standards for the provision of best-practice, evidence-based care.

    c. Payment methods that are linked to the attainment of beneficial care outcomes rather than the delivery of care activities irrespective of outcome.

    d. Effective and integrated technologies to support accurate, efficient collection, analysis, and dissemination of data.[53]

[50] New South Wales Government. Value based healthcare [Internet]. December 17 2019. Available online: https://www.health.nsw.gov.au/Value/Pages/default.aspx

[51] Council of Australian Governments (COAG). Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform [Internet]. February 2018. Available at: https://www.coag.gov.au/sites/default/files/agreements/heads-of-agreementhospital-funding.pdf.

[52] Woolcock K. Value Based Health Care: Setting the Scene for Australia [Internet]. Deeble Institute for Health Policy Research No. 31. Deeble Institute and the Australian Healthcare and Hospitals Association (AHHA). June 11 2019. Available online: https://apo.org.au/sites/default/files/resource-files/2019/06/apo-nid240831-1365081.pdf

[53] Australian Commission on Safety and Quality in Health Care. The State of Patient Safety and Quality in Australian Hospitals [Internet]. Australian Commission on Safety and Quality in Health Care. 2019. Available online: https://www.safetyandquality.gov.au/sites/default/files/2019-07/the-state-of-patient-safety-and-quality-in-australian-hospitals-2019.pdf

62. The ANMF calls on the Government to:

i. Commit to supporting a sustainable long-term, national, cross-sector policy and strategy for enhancing and broadening uptake of value-based healthcare.

ii. Commit to supporting improved access and use of relevant and up-to-date data via the establishment of patient outcome and experience measures, clinical quality registries, improved health informatics infrastructure, international benchmarking.

iii. Work with stakeholders to develop a national health workforce strategy that supports models of care that enable value-based approaches to healthcare.

iv. Pursue the adoption of mixed funding formulae that appropriately utilise a blend of activity-, block-, and performance-related funding measures that incentivise the delivery of value-based healthcare.

Public Hospitals

63. To respond to rising healthcare costs to the public,[54] the ANMF urges the Australian Government to take responsibility for ensuring that overall spending on public hospitals remains affordable and that policy settings contain inflation. The Government must ensure that public hospital funding is directed to identified health priorities and is used efficiently to deliver safe and best practice care. Policy and regulatory controls, which control unnecessarily costly care, encourage avoidance of ineffective, care and reduce waste, should be developed and introduced.

64. In 2017-18 the Federal Government provided 41 percent of public hospital funding, and overall, hospitals accounted for the highest proportion of spending across all areas of health expenditure (40 percent)—$74 billion.[55] The Commonwealth Government spent $22.7 billion (39 percent) (not including payments made by the Australian Government as Medicare benefits associated with private patients) on public hospitals.

65. The ANMF argues that in the face of Australia's aging population,[56] increasing number and proportion of admissions, health care associated infections and preventable complications,[57] lengthening public hospital waiting times,[58] and emergency department ramping,[59,60] increased investment from the Commonwealth Government is necessary. While the COVID-19 pandemic has had varying impacts upon hospital access and activities,[61] these increases have largely intensified and now coming into 2021, it is anticipated that this will further increase.

66. Enhanced Commonwealth funding to public hospitals must facilitate improved access to services, including screening, mental health care, elective surgery, and emergency department services, and subacute care. The increasing expectations on public hospitals and staff to cope with the anticipated future productivity demands of an ageing population, a community impacted by the long-term and widespread effects of the COVID-19 pandemic, and greater pressure to cut waste means that substantial investment is required to supply adequate infrastructure and workforce capacity.

[54] Russell L Doggett J. A roadmap for tackling out-of-pocket healthcare costs [Internet]. Analysis and Policy Observatory (APO). February 2019. Available online: https://apo.org.au/sites/default/files/resource-files/2019/02/apo-nid219221-1331226.pdf
[55] Australian Institute of Health and Welfare. Australia's hospitals at a glance 2018–19 [Internet]. Australian Government. Cat. no. HSE 247. Canberra: AIHW. Available online: https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance-2018-19/summary
[56] Australian Institute of Health and Welfare. Older Australia at a glance [Internet]. Australian Government. September 10. Available online: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/report-editions
[57] Australian Institute of Health and Welfare. Admitted patient care 2017-2018 [Internet]. Australian Government. May 23 2029. Available online: https://www.aihw.gov.au/reports/hospitals/admitted-patient-care-2017-18/contents/at-a-glance
[58] Australian Institute of Health and Welfare. Elective surgery waiting times 2017-18 [Internet]. Australian Government. March 1 2019. Available online: https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-17-18/contents/summary
[59] ABC News. Third patient dies this year after ramping outside of Adelaide hospital [Internet]. Australian Broadcasting Corporation. November 18 2019. Available online: https://www.abc.net.au/news/2019-11-18/adelaide-hospital-ramping-third-patient-dies/11712776
[60] ABC News. Patients forced to wait in ambulances as emergency departments struggle with thousands of patients daily. Australian Broadcasting Corporation. January 22 2020. Available online: https://www.abc.net.au/news/2020-01-22/ambulance-ramping-increasing-emergency-departments-full/11887482
[61] Australian Institute of Health and Welfare. Hospital Activity [Internet]. Australian Government. 2020. Available online: https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-activity

67. Australia still lags behind many countries in terms of public reporting of healthcare safety and quality.[62] In line with the Productivity Commission's recommendations,[63] the ANMF argues that the public should have access to information regarding nurse and midwife staffing levels and patient health outcomes at all public hospital facilities. A large body of evidence supports the association between increased nurse staffing and improved quality of patient care. Public reporting of healthcare staffing patterns aims to incentivise hospitals to improve staffing by making comparison data available for consumers as well as staff and hospital administrators.[64] Public reporting of nurse and midwife staffing levels should form part of the mandatory public reporting requirements for public hospitals and would enable improved consumer decision-making regarding their preferences for care. Including these factors in mandatory public reporting could also provide public hospitals with incentives to meet benchmarks for improved health outcomes overall. Collection and reporting on this data may also be of use in ensuring that the hospital workforce is better able to respond to crises including natural disasters caused by climate changes and pandemic events.

68. Better use of technology including telehealth as has been seen during the COVID-19 pandemic is a central consideration for improving efficiency in public hospitals. Technology can better support connections between primary healthcare, and hospital care, and aged care by creating a more open infrastructure that allows multiple providers to connect to the same healthcare information. Technology improvements can improve efficiencies via more timely access to patient information for all clinical disciplines and via allowing people to readily access their own information self-management and patient empowerment is also supported.

69. Telehealth and technology can also be used to improve patient outcomes remotely by supporting people to actively participate in self-management, the delivery of team-based services across the health care continuum, integrating with financial incentives to drive healthcare providers to adopt best-practice care and wellness management process for patients, and through better monitoring and reporting of trends in patient outcomes to underpin continual quality improvement.

70. The ANMF calls on the Government to:

i. Substantially increase public hospital funding to a minimum of 50 percent of all public hospital funding to address the current workforce and patient safety issues and persistent under-resourcing.

ii. Adopt funding models that recognise growth, use incentives to encourage efficiency and a central focus on better outcomes for patients.

iii. Implement policy and funding incentives which focus on improvements to safety and outcomes rather than penalising public hospitals for adverse patient safety events.

iv. Introduce mandatory reporting on nurse and midwife staffing levels and patient health outcomes and reported outcomes by all public hospitals.

v. Implement improvements to technology, including access to basic infrastructure, reliable equipment and services (e.g. internet, telehealth) and providing education, training and support services for patients and providers.

vi. Move from volume and activity-based healthcare to value-based health care system to assist health care providers to refocus on delivering health outcomes rather than meeting activity targets.

[62] Australian Commission on Safety and Quality in Health Care. The State of Patient Safety and Quality in Australian Hospitals [Internet]. Australian Commission on Safety and Quality in Health Care. 2019. Available online: https://www.safetyandquality.gov.au/sites/default/files/2019-07/the-state-of-patient-safety-and-quality-in-australian-hospitals-2019.pdf

[63] Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Report No. 85. Canberra: Productivity Commission, 2017.

[64] De Cordova P B, Pogorselska-Mziarz M, Eckenhoff M E, McHugh M D. Pubic Reporting of Nurse Staffing in the United States. *JNR*. 2019;10(3):14-20.

National Disability Insurance Scheme (NDIS)

71. The ANMF supports the NDIS and strongly supports the Federal Government taking steps to ensure that the scheme is fully, sustainably, and appropriately funded. The ANMF is also pleased to see that the Australian Government has committed to developing an NDIS Participant Service Guarantee to support positive participant experiences with the Scheme.

72. The ANMF understands that implementation of the NDIS continues to be challenging, especially in relation to how the NDIS interfaces with non-NDIS services and can be complex and frustrating to navigate.[71,72] For example; services provided by local governments once subsidised via Home and Community Care funding may be unsustainable with transitions to the new scheme. The ANMF is supportive of the recommendations proposed in the Tune report to improve the participant experience, including new standards and processes to support the delivery of the Participant Service Guarantee.[73]

73. Providing for people affected by a disability is about ensuring that appropriate and accessible services and supports are in place to maximise the purpose, meaning, and quality of life for those living with disability. It is important to note that while having a disability is not always a health matter, disability may affect people who are impacted by other conditions, such as mental health issues.

74. Issues with NDIS coverage for people affected by mental health conditions means that some people who experience periods of disability may not be eligible for services funded through the NDIS. Likewise, those who are eligible for NDIS support may not have ready or equitable access to services, such as those living in regional and remote locations or from socially, culturally, or linguistically diverse backgrounds including Aboriginal and Torres Strait Islander people and younger people who require specialist disability accommodation.

75. The ANMF calls on the Government to:

i. Continue to monitor and assess the rollout of the NDIS with focus on ensuring equitable coverage for those that experience disability linked to mental health conditions and those from socially, culturally, or linguistically diverse backgrounds including Aboriginal and Torres Strait Islander people and younger people requiring specialist disability accommodation.

ii. Implement the recommendations in the Tune Review.[74]

Private Health Insurance

76. While the ANMF acknowledges the need for an effective private health system, we do not support the current level of public contribution via premiums. Private health insurance premiums are too high and do not provide reasonable return for all taxpayers and the wider community, in either health or economic terms. The ANMF encourages the Federal Government to introduce legislation that would ensure that private health insurance providers return a minimum of 90 per cent to customers across the industry. Enforcing a minimum payout ratio would also reduce premiums across the board, improving affordability to customers and incentives to business to operate more efficiently.

[71] Parliament of Australia. Progress Report 2019: General issues around the implementation and performance of the NDIS [Internet]. Commonwealth of Australia. 29 March 2019. Available online: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/General_NDIS/Report

[72] Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report

[73] Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report

[74] Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report

77. The Australian Government's private health insurance rebate system is uneconomic and the Australian public's perception is that it is poor value for money.[75] The Federal Budget loses billions of dollars (projected at $AUD 6.8 billion in 2021) and the Australian consumer is paying higher premiums despite low wages growth, reduced insurance coverage, greater out-of-pocket expenses, increasing numbers of exclusionary policies, and little impact upon the pressure on the public hospital system. It is expected that much of this will also be amplified by the impact of COVID-19.

78. Private health insurance returns only 84 cents in the dollar due to financial overheads, while Medicare returns 94 cents after the costs of tax collection. This means that private health insurance may be driving up the cost of healthcare, which detrimentally impacts all Australians, but most critically, Australia's most vulnerable. Again, this is of particular urgency and concern in relation to the widespread impacts of the COVID-19 pandemic.

Low-value private health insurance policies

79. Low-value and low-cover private health insurance policies neither provide benefit for policy holders nor any relief to the public hospital system. Often, these policy types – or "junk policies" are designed to allow policy holders to avoid the financial penalties for having no cover at all (see below), but can be both poor value for money, provide substandard cover, and incur high out-of-pocket expenses.

Financial penalties for lack of cover

80. The penalty for not holding private hospital insurance is discriminatory and unfair; penalising those over 30 years of age who do not hold cover a cumulative 2 percent loading per year (up to 70%) via the Medicare Levy Surcharge. This means that someone who does not take out private hospital insurance until the age of 40 will pay 20 percent more than if they had taken out insurance at 30. This has an especially adverse impact upon Australians who cannot afford private hospital insurance or who do not wish to take out cover as it would be of little benefit due to lack of access to healthcare such as people living in regional and remote locations.

Complex policy information

81. As indicated above, the Australian private health insurance field is marked by complex information from competing sources. Consumers need clear, accessible information from reputable sources in order to make sense of and decide upon whether private health insurance is right for their individual situations and if so which cover and what provider.

82. Practical policy reforms to enhance the affordability and value of private health insurance, and to reduce the subsidisation of private health insurance at the expense of the public health systems, need to occur.

[75] Roy Morgan. Why have private health insurance? [Internet]. January 25 2019. Available online: https://www.roymorgan.com/findings/7849-why-have-private-health-insurance-201901250537

83. The ANMF calls on the Government to:

i. Ensure that private health insurance providers pay out a minimum of 90 percent to customers across the industry.

ii. Remove the public subsidy of private health insurance. This could be done gradually – a 10 percent reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals with less than a 2 percent reduction in private health insurance coverage.

iii. Cut ancillary rebates, starting with removal of rebates for treatments with a poor evidence base. The savings from changes to the rebate should be redirected to the public health system.

iv. Discontinue the availability of junk policies that are designed to solely avoid the Medicare Levy Surcharge while providing only minimal cover.

v. Remove financial penalties for those who do not take out private health insurance regardless of their income, with a particular focus on Australians living in regional and rural Australia who receive very little benefit from holding private health insurance.

vi. Enhance reporting requirements, analysis and data sharing to inform health outcomes, information about systems performance, adverse events and cost effectiveness;

vii. Enhance regulation to ensure transparency from private health insurance companies regarding policy comparisons, eligible cover, exclusions, and consumer exposure to out-of-pocket expenses particularly for low cost policies. This could be done by establishing an independent regulatory body for the sector.

viii. Enable insurers to fund evidence-based contemporary models of care, where there is evidence of comparable or superior health outcomes and cost savings. This should include the funding of midwife- and nurse-led models of care.

ix. Ensure that information from providers for consumers is simplified, transparent regarding cover and payout, standardised, and easily accessible.

x. Examine initiatives to enhance access to health care for regional and rural Australians so that they can extract value from private health insurance despite geographic distance.

PUBLIC HEALTH, PREVENTIVE HEALTH, AND PRIMARY HEALTH CARE

Public health, preventive health, and primary health care are key priorities in Australia that are heavily reliant upon a suitably sized, educated, and supported nursing and midwifery workforce. The importance of public health, preventive health and primary health care is even greater due to the widespread impacts of COVID-19 on the Australian community. Nurses and midwives working in public health and preventive health provide life-saving immunisation, educate people about the need for regular health checks, identify risks for illness and chronic disease, and offer support and care for mothers and babies. Nurses and midwives must be at the centre of public and preventative health strategies both as part of their normal daily work routines, and as also experts in collaborating with other multidisciplinary healthcare professionals and experts to achieve intended outcomes in policy and practice. Historically, public health and preventative health as well as the role of nurses and midwives in these fields, is often overlooked by policy makers more focused on acute hospital services. This is reflected in the level of past expenditure on preventative health activities in Australia. The COVID-19 pandemic has taught us the urgent importance of a strong, well-funded public, preventive, and primary health care sectors and the ANMF urges the Government to invest and support improvements in these areas as a matter of priority.

84. Overall, Australia's health system performs very well. This continues to be true in relation to Australia's response to the COVID-19 pandemic. However, unacceptable deficiencies continue to exist. While life expectancy has increased, Australians spend a relatively higher number of years in ill-health, both in absolute terms and as a share of life expectancy. On both of these measures, Australia ranks second highest behind only Turkey and the United States, among a range of OECD and other developed countries.[76] The gap between overall health outcomes and indigenous health outcomes continues to be a disgrace,[77] while people in rural areas,[78] and lower socio-economic groups,[79] live shorter lives and experience more illness than those living in major cities and with higher incomes. These gaps may be expected to widen further as a result of the widespread impact of the COVID-19 pandemic on many and especially Australia's most vulnerable populations.

[76] Productivity Commission. Shifting the Dial: 5 Year Productivity Commission Review [Internet]. Australian Government. 2017. Available online: https://www.pc.gov.au/inquiries/completed/productivity-review/report
[77] Australian Institute of Health and Welfare. Indigenous Australians [Internet]. Australian Government. Available online: https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview
[78] Australian Institute of Health and Welfare. Rural and Remote Health [Internet]. Australian Government. October 22 2019. Available online: https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health
[79] Australian Institute of Health and Welfare. Australia's health 2018 [Internet]. Australian Government. Available online: https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents

85. These groups have poorer access to primary care, aged care, mental health care, maternity services, dental care, allied health and specialist services and are more likely to experience problems related to obesity, alcohol use, and smoking.[80] These gaps and deficiencies must be addressed through improved preventive health care nation-wide.

86. Not only is prevention better than cure, it makes the most economic sense. With an increasing chronic disease, cancer, and mental ill health burden, an ageing population, and many people in poorer health often from avoidable conditions, who are generally less productive,[81] it makes sense to invest where we can reap the most benefit. Investing in preventive health now will also enable a more effective and timely response to the impact of COVID-19 which are likely to be felt for many years.

87. The rising costs of healthcare can be curtailed effectively through investment in prevention, detection, and early treatment through a strong public health sector, primary care services, and effective primary health care. The Productivity Commission reported that about 750,000 hospital admissions could be avoided if we had effective intervention in the weeks leading up to hospitalisations. At around 1.34 percent, the Australian Government lags behind other OECD countries in terms of preventive health spending. Adequately funded, remodelled primary health care is critical.

88. The ANMF calls on the Government to:

i. Re-establish a national dedicated preventive health body.

ii. Increase the proportion of total health expenditure spent on preventive health to a target of 5 percent.

iii. Increase incentives to encourage changes in both health provider and community member behaviour and knowledge, which will lead to better health outcomes and reduced health and aged care costs.

iv. Establish public health programmes and preventive primary care systems that encourage people to enrol in wellness maintenance programs as is now occurring widely throughout the world. This approach encourages people to take responsibility for their own health with assistance from a multidisciplinary range of health professionals such as General Practitioners and NPs.

v. Ensure that public and primary health networks focus on disease prevention, health promotion, equity and social determinants of health and receive sustainable funding to maintain evidence-based programs found to be effective.

vi. Investigate better and more efficient ways to fund and manage chronic conditions mental ill health, and illnesses, e.g. blended payment models, nurse- and midwife-led models.

vii. Establish funding arrangements which support the use of a wider range of health professionals in chronic and complex care in preventive and primary care including NPs.

viii. Ensure that private health insurance companies are restricted from operating in primary care. Allowing private health insurance companies into this domain will increase inequity and reduce efficiency.

[80] Australian Institute of Health and Welfare. Australia's health 2018 [Internet]. Australian Government. Available online: https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents

[81] Productivity Commission. Mental Health Draft Report [Internet]. Australian Government. October 2019. Available online: https://www.pc.gov.au/inquiries/current/mental-health/draft

GENERAL PRACTICE AND PRIMARY HEALTH CARE

Nurses in general practice work at the forefront of primary healthcare across a variety of metropolitan, rural, regional, and remote areas. As one of the fastest growing areas within healthcare, investment in nurses working in general practice and primary healthcare is vital for ensuring good health and wellbeing across women's health, men's health, aged care, infection control including COVID-19, chronic disease management including cardiovascular, asthma and diabetes care, immunisation, cancer management, mental health, maternal and child health, health promotion, population health, wound management, illness prevention and much more. Nurses working in general practice and primary healthcare are a key part of necessary changes in the delivery of primary health care in Australia.

89. There are around 14,000 nurses working in general practice.[82] While the numbers of nurses employed in the Australian general practice environment has risen rapidly over the past decade as a result of a positive policy environment and enhanced funding of nursing services, only around 63 percent of general practices employ at least one nurse. Workforce growth in general practice has so far occurred in a somewhat ad hoc manner as a response to various funding schemes and a gradual drive toward improved primary health care, rather than being a carefully planned workforce development. This has raised a number of challenges for the nursing profession around the role of the nurse in general practice, the nurse's scope of practice and continuing professional development opportunities. A study undertook simulation modelling on the general practice nursing workforce for 2012-25 and resulted in an estimated shortfall of 814 full time nurses in general practice by 2025.[83]

90. Prior to 2012, the Medicare Benefit Schedule (MBS) provided specific item numbers for the delivery of nursing services, such as, cervical smears, immunisations and wound care, provided 'for and on behalf of' a GP. For each occasion of nursing service, remuneration was provided to the practice from Medicare. This funding model significantly impacted on the services that were delivered by nurses in general practice.

91. On 1 February 2020 the Workforce Incentive Program (WIP) – Practice Stream began as part of the 2018/2019 Stronger Rural Health Strategy.[84] This program provides incentive payments to accredited general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services to offset the employment of NPs (only those without an MBS provider number), RNs, ENs, and now allied health and pharmacy staff depending upon locally assessed community needs. Only some practices will be eligible to receive the maximum incentive payment of $AUD 125,000, which may further reduce the funding available to employ nurses in general practice.

[82] Australian Primary Health Care Nurses Association (APNA). General Practice Nursing [Internet]. 2017. Available at: https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/general-practice-nursing
[83] Heywood T, Laurence C. The general practice nurse workforce: Estimating future supply. *AJGP.* 2018;47(11):788-95.
[84] Australian Government Department of Health. Workforce Incentive Program Questions and Answers [Internet]. Australian Government. October 31 2019. Available online: https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-wip-questions-and-answers

92. The ANMF argues for the removal of the restriction in WIP – Practice Stream funding for the numbers of nurses employed being tied to the number of GPs in a practice via the Standardised Whole Patient Equivalent (SWIPE), in order to access payment. This would enable more nurses to be employed within general practice and better meet community needs. The ANMF also argues for quarantining of funding in the WIP – Practice Stream to ensure that funding for the employment of nurses is not spent on employment of other health professionals.

93. Nurses in general practice continue to be paid considerably less than their nursing colleagues in the acute care sector. Their conditions of employment including entitlements such as leave loading, on-call rates, shift penalties, weekend allowances, annual leave, and qualifications allowance are also inferior. As has been undertaken for medical registrars in general practice, national terms and conditions for the employment of RNs and ENs in general practice should be developed as a priority.

94. The retention of some MBS item numbers has meant that the intent of the WIP to enhance the role of nurses working in general practice has not been fully achieved. Funding remains tied to specific services only. This in turn perpetuates a model whereby employers may direct nurses to focus care only on those activities that can be billed through Medicare. These item numbers are for: health assessments, chronic disease management, antenatal care, and telehealth (10983, 10987, 10984, 16400, 10997, and 10984).

95. The ANMF calls on the Government to:

i. As the highest priority, remove the remaining five MBS items numbers for nurses in general practice (10983, 10984, 10987, 10997, 16400) and increase the WIP payment accordingly.

ii. Review the eligibility rules for the Workforce Incentive Program (WIP) – Practice Stream to ensure that the employment of nurses is not detrimentally impacted by funding rules.

iii. Allow NPs with their own provider number to also be eligible to receive the WIP practice stream funding.

iv. Allow NPs to employ other nurses under the WIP practice stream in the same way as GPs.

v. Invest in recruitment and retention polices and activities to address the predicted shortage of nurses in general practice and relatively low employment rates of nurses within Australian general practices.

vi. Fund the development of national terms and conditions for the employment of RNs and ENs in general practice. As the professional and industrial organisation representing more than 300,000 nurses, midwives, and carers in Australia, the ANMF is best placed to conduct this activity.

MENTAL HEALTH

Mental Health Nursing

Nursing plays a central part in providing high quality, holistic, and accessible mental health care to those individuals in need. All nurses provide mental health care, with many mental health nurses also possessing post graduate mental health specialist qualifications. With the existing and likely long term impacts of the COVID-19 pandemic on almost every facet of everyday life, mental health has become even more of a priority concern in terms of the Australian community's health and well-being particularly for our most vulnerable. People with pre-existing mental ill health, those who have developed conditions more recently, and the strained healthcare workforce need specific and sustained attention and investment to ensure that the COVID-19 pandemic isn't closely followed by a predicted mental ill health and suicide crisis.[85,86,87]

96. Nurses are well positioned to understand the complex interrelationship between physical and mental health and to respond to the high premature mortality/morbidity rates of individuals being treated for mental health issues caused by physical illnesses, such as cardiac disease, diabetes, and metabolic related orders and the impact of the COVID-19 pandemic.

97. Early prevention, early diagnosis, and identifying mental ill health and suicide risk in the treatment and management of mental health problems are essential in achieving positive outcomes for individuals. Often a first point of contact for people in the community, nurses are, on many occasions, best placed to ensure these critical interventions occur through timely referral and care. This is especially vital in rural, regional, and remote areas where access to specialised mental health services and general practice is more limited and can also be true for disadvantaged metropolitan populations in the community (e.g. socially, culturally, and linguistically diverse and/or disadvantaged people) and in aged care. Social isolation, financial strain, job losses, and decreased access to mental health services and support due to COVID-19 has also challenged the provision of mental health services and support and must be urgently addressed.

98. The 2018 Senate Community Affairs References Committee Inquiry into Accessibility and quality of mental health services in rural and remote Australia highlighted the fact that although Australians living in rural and remote areas are impacted by mental disorders at the same rate as people living in major cities, they experience unique barriers to receiving care. Specialist mental health nurses and an overall well-equipped workforce of trained RNs is vital to the delivery of mental health care to meet Australia's current and future needs and ANMF contends that nurses are currently underutilised in meeting the demand for mental health care, across all geographical areas, but especially in rural and remote settings.

[85] John A, Pirkis J, Gunnell D, Appleby L, Morrissey J. Trends in suicide during the covid-19 pandemic BMJ 2020; 371:m4352.
[86] Banerjee, Debanjan et al. "'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention." Psychiatry research vol. 295 (2021): 113577. doi:10.1016/j.psychres.2020.113577
[87] Hai Le, MD; Burhan Ahmed Khan, MD; Syed Murtaza, MD; Asim A. Shah, MD. The Increase in Suicide During the COVID-19 Pandemic. Psychiatric Annals. 2020;50(12):526-530 https://doi.org/10.3928/00485713-20201105-01

99. Better choice and more accessible mental health care could be provided to people through different models of care, such as mental health nurse-led models, including mental health NP-led models; an increase in school nurse positions in the public school sector (for early intervention); and, quarantining of the Mental Health Nurse Incentive Payment (MHNIP) funding within Primary Health Networks to enable reinstitution of the excellent work that had been undertaken by mental health nurses in keeping people well and living in their community. Mental health nurses, NPs, and skilled RNs are also well positioned to provide necessary care to residents in aged care facilities and people receiving aged care and/or disability support in the community.

100. Mental health services must also be appropriately tailored, accessible, and to provide effective, safe, and meaningful care to the diverse Australian population. Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people (including asylum seekers, new migrants, and refugees), socially disadvantaged, and sexually and gender diverse people all face barriers to accessing safe, quality care that meets their specific needs and preferences.

101. As a workforce development strategy, the ANMF recommends that initiatives need to be developed and incentives need to be in place to retain the experienced mental health nursing workforce and recruit and mentor nurses new to mental health, to help grow the mental health nursing workforce. This includes transition to practice programs to equip both newly qualified and experienced RNs with the specialist skills required in mental health nursing.

102. The ANMF calls on the Government to:

i. Review current programs and increase mental health funding to address the widespread impact of COVID-19 on the Australian community's mental health and wellbeing, particularly for the most vulnerable groups.

ii. Develop a clearly articulated policy framework that underpins health service provision, ensuring that the experience of mental health does not lead to and entrap individuals within homelessness.

iii. Provide adequately funded community-based mental health nursing services that can deliver a timely, flexible, tailored response and that seeks to address the current gap, in accessing after hours mental health care.

iv. Provide for more community based mental health in-reach nursing services to support aged care residents.

v. Invest in building mental health knowledge capacity in the nursing workforce, particularly in rural and remote areas, through resumption of quarantined scholarships for continuing professional development (CPD) and postgraduate level for registered nurses and NPs in mental health;

vi. Provide positions for mental health NPs with funding models which broaden access for people seeking mental health care and which facilitate viable and sustainable practice operation.

vii. Conduct a public awareness campaign to address stigma attached to those experiencing mental health issues.

viii. Ensure all people experiencing mental health conditions can access effective, quality mental health care that acknowledges their particular needs and preferences for culturally safe and appropriate care particularly for Aboriginal and Torres Strait Islander people, and those from socially, culturally and linguistically diverse and/or disadvantages backgrounds including asylum seekers, new migrants, and refugees, and sexually and gender diverse people.

ix. Ensure funding and support for mental health programs and interventions targeted towards healthcare professionals and staff impacted both directly and indirectly by the COVID-19 pandemic.

RURAL AND REMOTE HEALTH

People who live in rural areas have a shorter life expectancy and higher levels of illness and disease risk factors than those in major cities. In many rural and remote locations, there is only access to public health care services due to limited or no other healthcare providers. Drought, natural disasters, and the widespread impact of COVID-19 on communities, workforces, and travel, and international trade disputes have intensified the pressure and strain on people living in rural and remote areas.

103. The majority of healthcare providers in rural and remote locations are nurses. Therefore, nurse-led health care is an essential component of health care delivery in these areas. Better choice could be provided to people in rural and remote areas through allowing nurses to work to their full scope of practice and providing different models of care, especially nurse practitioner led models.

104. Small rural maternity units can provide safe birthing services. Mothers and babies are placed at risk when these services are not available locally. Closing rural maternity services doesn't make economic sense for families or the health care system. It also reduces the opportunities for midwives to work in the bush. This exacerbates the workforce shortages that often lead to these closures in the first place. Timely Government investment can reverse this downward spiral. Nurses are the most geographically well-distributed health professional. The prevalence of midwives decreases with distance from the urban centres. Support should be given to RNs in rural areas to complete the postgraduate midwifery education required to become dual registered, as both a registered nurse and midwife.

105. The ANMF calls on the Government to:

i. Fund designated salaried positions for NPs in small rural and remote communities;

ii. Provide specific scholarships for RNs in rural and remote locations to undertake postgraduate midwifery education;

iii. Remove the restriction on rural and remote scholarship applicants by allowing access for those solely employed by state/territory governments;

iv. Require the Health Workforce Agencies to establish a national advisory committee, which includes nursing and midwifery professional organisation representatives, to provide oversight for the Health Workforce Scholarship Program; and

v. Ensure Health Workforce Scholarship data is collected by the Health Workforce Agencies and made publicly available by the Australian Government.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

The ANMF has a long-held vision of health equity for Aboriginal and Torres Strait Islander peoples. In order to achieve this, the ANMF builds relationships with Aboriginal and Torres Strait Islander nurses, midwives, assistants in nursing, and broader communities, working together to identify and provide opportunities to build capacity and realise potential.

106. We continue to work towards our vision through our Reconciliation Action Plan, demonstrated by modelling respect for Aboriginal and Torres Strait Islander peoples; promoting understanding of their rights and leading the nursing and midwifery professions in respect and sharing knowledge with Aboriginal and Torres Strait Islander peoples.

107. The ANMF adopts the principles of reconciliation as part of our core work, and models and encourages promotion of reconciliation throughout the nursing and midwifery professions.

108. Nurses and midwives constitute more than half of the entire health workforce. Aboriginal and Torres Strait Islander registered nurses and Aboriginal and Torres Strait Islander midwives, however, make up less than 1 percent of these professions.

109. The presence of Aboriginal and Torres Strait Islander health professionals makes a positive difference to service access, experiences, and outcomes for Aboriginal and Torres Strait Islander people. Given they have the worst health outcomes in the country it is essential that strategic and long-term efforts are made to increase the overall number and representation of Aboriginal and Torres Strait Islander nursing and midwifery students and graduates across all jurisdictions.

110. There is consistent evidence that when Aboriginal and Torres Strait Islander peoples work in the health system, Aboriginal and Torres Strait Islander people are more likely to access services and gain assistance earlier with consequent improvements in health outcomes and reductions in long term health expenditure.

111. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) is the national health professional peak body for Aboriginal and Torres Strait Islander nurses and midwives. In the early 1990s, the ANMF (then ANF) provided significant support for the establishment of the then Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN). There is an historical and ongoing close relationship between the ANMF and CATSINaM.

112. CATSINaM receives triennial grant funding from the Australian Government for their operations. Their role in providing support for Aboriginal and Torres Strait Islander nurses and midwives, nursing and midwifery stakeholders and Governments, and building the current workforce of Aboriginal and Torres Strait Islander nurses and midwives is essential.

113. The excellent work of CATSINaM in elevating the profile of their national organisation, building their Aboriginal and Torres Strait Islander nurse and midwife membership, advocating for their members, supporting recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing and midwifery and participating in research and workforce development should continue to be supported and funded.

114. The ANMF calls on the Government to:

i. Provide increased ongoing funding to CATSINaM to provide leadership for nursing and midwifery organisations to work towards health equality for Aboriginal and Torres Strait Islander peoples and to continue to support and grow the Aboriginal and Torres Strait Islander nursing and midwifery workforce.

ii. Establish a caucus of Aboriginal and Torres Strait Islander health organisations and representatives to provide regular and ongoing consultation on policies and activities that affect Aboriginal and Torres Strait Islander health and wellbeing.

iii. Support the increase of the Aboriginal and Torres Strait Islander nursing and midwifery workforce to 5% of the total Australian nursing, midwifery, and assistant in nursing workforce across health and aged care.

iv. Endorse and support the development and implementation of a National Aboriginal and Torres Strait Islander Nursing and Midwifery Workforce Strategy.

v. Provide funding and support for the development, implementation, and evaluation of Birthing on Country programs in urban, regional, and remote locations.

vi. Substantially increase funding to community-controlled, targeted, evidence-based strategies for Aboriginal and Torres Strait Islander healthcare across the life course.

vii. Endorse and support the implementation and roll-out of nurse- and midwife-led models of care that address Aboriginal and Torres Strait Islander health concerns and challenges.

viii. Endorse and support the development and implementation of a National Aboriginal and Torres Strait Islander Aged Care Workforce Strategy.

ix. Fund and support the national uptake of CATSINaM's cultural safety training at all levels of healthcare service, education, and training to ensure that all healthcare professionals and educators receive best-practice cultural safety training.

x. Support the inclusion of cultural safety training into the annual registration and continuing professional development requirements of all healthcare professionals.

xi. Support the inclusion of measures of cultural safety with all health and aged care service providers into the National Safety and Quality Health Service Standards.

xii. Support a revitalised nation-wide approach to addressing Aboriginal and Torres Strait Islander health and wellbeing inequalities including greater partnerships with Aboriginal and Torres Strait Islander peak bodies and leaders.

xiii. Make a true and concerted effort to get each of the Closing the Gap targets on track including greater funding.

xiv. Expand the Closing the Gap initiative by adding additional targets linked to incarceration, community violence, disability, aged care, and children in out of home care.

CLIMATE CHANGE AND HEALTH

As frontline health professionals, nurses and midwives see the impact of climate change on the health of individuals and communities for whom they provide care. Nurses and midwives see the direct effects from storms, drought, flood, and heatwaves; they experience the indirect effects from altered water quality, air pollution, land use change, and ecological change. The health effects include mental illness, cardiovascular and respiratory diseases, infectious disease epidemics including COVID-19, injuries, and poisoning.[88] The COVID-19 pandemic risks ongoing inactivity regarding Government-led responses to climate change and the ANMF urgently recommends that the Commonwealth Government begin serious action immediately to prevent further damage and risk to the health and wellbeing of current and future generations as a result of the climate crisis.

115. Adverse health effects on individuals and communities will obviously impact health systems and health care delivery, with the treatment of climate change-related health conditions adding to the burden of an already stretched health care workforce.[89] A wealth of evidence demonstrates that comprehensive and practical governments responses to climate change, including significant policy and investment commitments, are urgently needed and must occur immediately before irreversible damage occurs.

116. The ANMF, as a member organisation of the Climate and Health alliance (CAHA), supports the Our Climate, Our Health campaign. We endorse the Campaign's call for the urgent development of a National Strategy on Climate, Health and Well-being for Australia. A Framework for a National Strategy on Climate, Health and Well-being has been developed by CAHA members, including the ANMF, to support a coordinated approach to tackling the health impacts of climate change in Australia; and, to assist Australian policymakers and communities in taking advantage of the health opportunities available from strengthening climate resilience, reducing emissions and protecting our ecosystems. The actions within this Strategy will protect Australian communities from the health impacts of climate change while supporting the Australian Government to meet its international obligations under the Paris Agreement. Our members want the Australian Government to take a strong stance on climate change mitigation policies and actions.

117. To prepare the health sector to deal with existing and future health effects of climate change, we need a viable workforce and environmentally sustainable workplaces. This means commitment to, and investment in, improvements in working conditions within the health and aged care sector which already does, and will increasingly, feel the effects of health care issues resulting from climate change most evident in the recent widespread natural disasters from 2019 bushfires and the COVID-19 pandemic.

[88] The Lancet Commissions. Health and climate change: policy responses to protect public health. Published online June 23, 2015. Available at: www. thelancet.com
[89] Australian Nursing & Midwifery Federation. ANMF Policy: Climate change. Reviewed and re-endorsed May 2015. Available at: http://www.anmf. org.au

118. In many Australian health facilities, nurses and midwives are leading the way in introducing environmentally sustainable systems into their workplace practices. These initiatives should be acknowledged, applauded, replicated, and appropriately funded throughout all health and aged care facilities and care delivery settings.

119. As the largest member nation of the South Pacific region, which is the most adversely affected region globally, by the impacts of climate change, the Australian government also has a regional responsibility for leading the way in terms of actively supporting its closest neighbours to respond to and mitigate the detrimental effects of climate change. Low-resourced South Pacific communities and health care systems are already struggling with the current impacts of climate change on physical and mental health as well as broader impacts upon living conditions, agriculture, and ways of life. Government aid and strong, proactive leadership responding to climate change and its effects is urgently required.

120. The ANMF calls on the Government to:

i. Develop and implement a standalone, National Plan on Climate, Health and Well-being based on the Framework developed by the Climate and Health Alliance (CAHA).

ii. Invest in a sustainable health workforce to prepare the health sector to deal with existing and future health effects of climate change including increased government funding for climate-resilient health systems and climate change mitigation research.

iii. Fund programs and initiatives that support those most adversely impacted by climate change including people living in drought and natural disaster affected regions in Australia and neighbouring regions in the South Pacific.

iv. Ensure a staged transition to zero emissions energy sources as a matter of urgency to avoid dangerous and irreversible impacts on the environment and the health of our communities by; developing a consistent energy policy to rapidly transition from fossil fuels to at least 50 percent renewable, zero-emission sources by 2030 including a clear strategy to ensure that that fossil fuels workforce is fairly and effectively supported and redeployed .

v. Reducing greenhouse gas emissions to exceed the current 2030 Paris carbon emissions target of 26-28 percent.

vi. Phasing-in a fair, and effective carbon tax that does not adversely impact Australian households.

vii. Investing greater funding in renewable energy technologies and programs.

viii. Developing proactive policies for mining and agriculture to reduce emissions and promote zero-emission technologies.

ix. Developing policies that support and incentivise zero-emission public and private transport technologies.

x. Funding states and territories to improve the energy efficiency of hospitals and the reduction of emissions from health and pharmaceutical industry sources.

xi. Support policies that reduce company, city, and personal environmental and climate impacts and that incentivise sustainability, zero-emissions options, and reduced environmental impact.

xii. Implementing ongoing avoided-deforestation and land clearing and reforestation policies and practices.

TAX JUSTICE

There must be an increase in government capacity to fund important services for the community through restructured taxation and fairer distribution of resources. However, the ANMF considers it to be unfair to ask average earners and ordinary taxpayers to carry an extra tax burden, while allowing large companies and corporations to pay less and, in many cases, for the profits reaped from Australians' work to flow out of the country.

121. There are other revenue streams available to the Government within existing tax structures which could be accessed to increase the overall pool of resources available to governments. There are also new revenue streams, widely used in the northern hemisphere, which could be accessed to increase revenue. This will require political will and commitment but it will lead to sustainability of our health system and other essential services providing for all Australians.

122. Corporate tax avoidance has become a major political, economic, and social issue in Australia and around the world in recent years. Most global trade is now between subsidiaries of multinational corporations and not between separate companies. This has enabled multinational corporations to structure their businesses in ways that allow them to shift profits from where they are generated to low or no tax jurisdictions. As a result, government budgets have been depleted and public services have been cut or are under pressure despite growing needs. This is the case with aged care funding and other public services in Australia.

123. The ANMF calls on the Government to:

i. Reform tax concessions - limit access to growing tax concessions such as superannuation, which bring most benefit to those with high incomes, could provide additional funding for essential public services;

ii. Require all entities receiving $10 million in annual government payments to file full and complete financial statements with ASIC (or ACNC for non-profits), with no exemptions.

iii. Eliminate reduced disclosure or special purpose filing options on annual financial statements filed with ASIC for subsidiaries of multinationals with over $500 million in annual revenues and any company with over $10 million in annual government payments.

iv. Establish a public register of beneficial ownership of all companies and trusts.

v. Further reduction or elimination of ASIC fees for accessing company information over the medium-term, including financial statements, particularly in a revenue-neutral framework (such as penalties for late-filing). ASIC fees are among the highest in the world; the UK and NZ have free access.

vi. Enhance the government's stapled structure reforms by including transparency measures to require any listed stapled structures, in which trusts derive a majority of income from related parties, to disclose the terms of all such transactions. This measure should also apply to any company, not necessarily stapled structures, that have annual government funding of over $10 million and that also have corporate structures with trusts receiving a majority of income from related parties.

vii. Introduce a Robin Hood tax – The ANMF believes that instead of disadvantaging ordinary people through tight budget measures, it is time the Government took and redistributed a larger share from those involved in the billions of dollars in financial transactions. The 'Robin Hood' tax, also known as a financial transactions tax, is a 0.05% tax on institutional trades of currencies, stocks, bonds, derivatives and interest rate securities. It is widely implemented across the European Union. If governments can tax ordinary Australians on basic requirements such as housing, then they certainly can and should tax international financial transactions.