australian nursing federation

Submission to the 'Towards a National Primary Health Care Strategy Discussion Paper'

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Executive Summary

The Australian Nursing Federation (ANF) applauds the Australian Government for putting the spotlight on primary health care, and absolutely supports the necessity for the development of a national primary health care strategy. The current suite of reforms, commissioned by the Government, enable a sensible integration of this strategy into the broader context of health and aged care services. Positioning primary health care at the centre of health policy should lead to significant improvements in health for all Australians across their lifespan.

Primary health care is fundamental and inherent to the philosophical base of the disciplines of nursing and midwifery.

The notion of 'first level contact of individuals, the family and community' as espoused in the international Declaration of Alma Ata[1] dovetails with accessibility to nursing and midwifery care as nurses and midwives practice across all geographic and socioeconomic spheres.

Nurses and midwives together form the largest health professional group in Australia, providing health care to people across their lifespan. Together they comprise over 55% of the entire health workforce.[2] Nurses and midwives are the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional and industrial organisations.

The ANF supports the view that there is a twofold benefit to embedding a well established primary health care sector within the country's approach to health care: reducing the demand on the acute sector while at the same time improving health outcomes and population health and well being.

Summary of Recommendations

While many points have been raised in this submission there are some particular issues on which the ANF makes specific recommendation to the External Reference Group.

The ANF recommends that:

1. To better meet the needs of the community, Medicare rebates and Pharmaceutical Benefits Scheme (PBS) subsidies be expanded to include appropriately qualified nurses and midwives for practice in all settings.
2. There be a fundamental shift in the focus of health care, encouraging prevention, early intervention, and direct easy access to appropriately qualified and skilled nurses, midwives and other health care professionals, within primary health care services provided locally.
3. There be a focus on the health care needs of the community, with new initiatives aimed at preventing ill health, delays in treatment and unnecessary hospitalisation, to deliver effective reform in the health system, with particular benefit for primary health care.
4. To provide better access for the community to primary health care services, funding models be developed in which the funding follows the person.
5. There be input from both community members and health professionals in the planning and implementation of their health care.
6. The implementation of an individual electronic health record system be expedited by the Government to facilitate rapid transfer of information across public and private facilities, primary, secondary and tertiary health care; and to provide a greater degree of transparency of a person's health records to all parties involved in that person's care.
7. Nurses and midwives are consulted in the development and implementation of health informatics.
8. Funding be provided for the existing workforce of nurses and midwives to undertake the necessary education to meet the Informatics Competency Standards required for nursing and midwifery practice.
9. There be funding invested in research to:
   - provide evidence on which to develop improved models of primary health care,
   - support nurses, midwives and other health professionals to undertake clinical loads as well as a research load,

...continued

ANF recommendations *continued*

- provide for research education and ongoing continuing professional development in research for nurses, midwives and other health care professionals,
- include the ability for primary health care centre health professionals to mentor novice researchers, particularly undergraduate nursing and midwifery students, and
- include the facility for consumers of the care of the primary health care centres to participate in research.

10. Primary health care computer capability be fully integrated with tertiary services, to enable timely access to, for example, patient discharge records, tests/treatments and secondary services to gain access to pathology or radiology results, and with local pharmacies for convenient prescribing.

11. Additional funding is provided to universities to ensure undergraduate nursing and midwifery courses:
    - move to an interdisciplinary model of education,
    - include primary health care in the curriculum, and
    - facilitate multidisciplinary models of practice.

12. For there to be effective team work in the primary health care sector, the following changes be made to policies and legislation governing the Medical Benefits Schedule (MBS) and PBS to allow:
    - prescribing rights for appropriately qualified nurses and midwives, and
    - the removal of the current 'for and on behalf of' restriction for nurses and midwives in the MBS.

13. Clinical placements for undergraduate nurses, midwives and other health care professionals be made available and funded across the full range of primary health care settings.

14. Increased numbers of Australian Government funded scholarships be made available for undergraduate and postgraduate nursing and midwifery students, and in particular, numbers of scholarships for nurse practitioners in primary health care settings.

15. Incentives available to rural and remote health professionals are equitable across the professions, in order to recruit and retain health care professionals.

16. There be an increase in funding for designated positions for nurse practitioners in primary health settings and especially in small rural and remote communities.

1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses and midwives, with Branches in each State and Territory of Australia.

As the largest professional and industrial organisation in Australia, the ANF has a membership of over 170,000 nurses and midwives, who are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors.

The core business of the ANF is the industrial and professional representation of our members and of the profession of nursing and midwifery.

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

The ANF applauds the Government for putting the spotlight on primary health care, and absolutely supports the necessity for the development of a national primary health care strategy. The ANF is pleased to respond to the Discussion Paper, *Towards a National Primary Health Care Strategy*, prepared by the Department of Health and Ageing with the External Reference Group for the National Primary Health Care Strategy (NPHCS).

2. Nursing and midwifery primary health care

2.1 Philosophical base

Nursing is a unique discipline which places a central emphasis on the holistic care of individuals, families, and communities. Nursing encompasses a person-centred approach to care, which places emphasis on early intervention, health promotion and illness prevention in theory and in practice.

Nurses work to promote good health, prevent illness, and provide care for the well and the ill, disabled and dying. Nurses also work in non-clinical roles in the promotion of a safe environment; in education and in advocacy; they conduct research; and participate in developing health policy and systems of health care management.[3]

Nursing places considerable emphasis on the relationship between health and human rights. This is clearly articulated in nursing's codes and standards of practice. *The Code of Ethics for Nurses in Australia (2008)* outlines the importance of nurses "recognising, respecting, actively promoting and safeguarding the right of all people to the highest attainable standard of health as a fundamental human right".[4]

The *Code* gives specific recognition of Australia's Aboriginal and Torres Strait Islander people as the "traditional owners of this land, who have ownership of and live a distinct and viable culture that shapes their world view and influences their daily decision making which includes their health."[5]

Also highlighted in the *Code* is the acknowledgement by nurses of "the diversity of people constituting Australian society, including immigrants, asylum seekers, refugees and detainees, and the responsibility of nurses to provide just, compassionate, culturally competent and culturally responsive care to every person requiring or receiving nursing care"[6]

The discipline of midwifery likewise fosters the concepts of primary health care as outlined in the following statement from the *Code of Ethics for Midwives in Australia* (2008):[7]

> *Midwives value their role in providing health counselling and education in the broader community as well as for the woman and within the family. Midwives individually and collectively, encourage professional and public participation in shaping social policies and institutions; advocate for policies and legislation that promote social justice, improved social conditions and a fair sharing of community resources; and acknowledge the role and expertise of community groups in providing care and support for each childbearing woman.*

As for nurses, the midwives' ethical code includes acknowledgement of Australia's cultural diversity and the responsibility midwives have to incorporate into their practice *the protection of cultural practices which will be beneficial to each woman, her infant(s), partners and families, and to be alert to act to mitigate any cultural practices which may cause harm.*

Midwives work in a unique partnership with the woman and give support, care and advice during the antenatal period, during birth and in the postpartum period, and care for the newborn and infant. Midwifery care includes health counselling and education, not only for the woman, but also within the family and the community. Involved in this is antenatal education and preparation for parenthood, the health of the woman, sexual or reproductive health and care of the young child.

Primary health care is fundamental and inherent in the philosophical base of the disciplines of nursing and midwifery.

2.2 Primary health care defined

In its Primary Health Care position statement, the ANF[8] maintains that "Primary health care acknowledges a social view of health and promotes the concept of self reliance to individuals and communities in exercising control over conditions which determine their health".

Primary health care is seen by the ANF to be:

> *…both an approach to dealing with health issues and a level of service provision. As an approach it deals with the main health problems and issues experienced by the community. It may include care and treatment services, rehabilitation and support for individuals or families, health promotion and illness prevention and community development.*[9]

The ANF fully supports the Declaration of Alma Ata assertion that:

> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*[10]

The ANF, as part of a group of leading nursing and midwifery professional organisations in Australia, strongly supports the adoption of primary health care as the centerpiece of health policy in Australia to improve the health for all Australians across their lifespan.[11]

2.3 Practice of nursing and midwifery

The notion of 'first level contact of individuals, the family and community' dovetails with accessibility to nursing and midwifery care, as nurses and midwives practice across all geographic and socioeconomic spheres.

Nurses and midwives together form the largest health professional group in Australia, providing health care to people across their lifespan. Nurses and midwives are the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional and industrial organisations.

There are 12,000 registered midwives and a combined total of 244,360 registered and enrolled nurses in Australia. Nurses and midwives comprise over 55% of the entire health workforce.[12]

In relation to nurses, the International Council of Nurses position statement, *Nurses and Primary Health Care,*[13] states:

> *Nurses are the principal group of health personnel providing primary health care at all levels and maintaining links between individuals, families, communities and the rest of the health care system. Working with other sectors, other members of the health care team or on their own, nurses explore new and better ways of keeping well, or improving health and preventing disease ad disability. Nurses improve equity and access to health care and add quality to the outcome of care.*

The practice of midwives' is described as being woman centred; a primary health care discipline founded on a partnership relationship between women and their midwives. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking a healthy process. Midwives focus on a woman's health needs, her expectations and aspirations and recognise every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals.[14] Midwifery care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.[15]

Nursing and midwifery are key professions to engage in achieving the aim of providing a primary health care strategy which will meet the needs of the Australian community.

2.4 Consensus View

The ANF, in conjunction with the Australian Practice Nurses Association, the Australian College of Nurse Practitioners, Royal College of Nursing, Australia and the Australian College of Mental Health Nurses, have developed a consensus statement in relation to the role of the registered nurse and nurse practitioner in primary health care. These organisations agreed that "the health reform agenda in Australia offers a unique opportunity to consider an enhanced model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model to offer comprehensive, patient centred primary health care services"[16] The present suite of health reforms also provide an opportunity to broaden Australia's health policy and funding strategies from a narrow focus on hospital based care and the treatment and cure of already established conditions, to health promotion and early intervention to prevent disease and injury within a primary health care milieu.[17]

The consensus statement to which ANF is a participant further states that:

> *Recognition of the role of nurses in primary health care is increasing nationally[18] and internationally[19] and is seen as essential to achieving improved population health outcomes and better access to primary health care services for communities. A broader role for nurses enables services to focus on the prevention of illness and health promotion, and offers an opportunity to improve the management of chronic disease as well as reduce demand on the acute hospital sector.[20]*

Some important points from the consensus statement referred to must be brought to the attention of the External Reference Group. From their combined perspectives and extensive experience in the primary health care field, the parties to the consensus statement provide an overview of the role of the registered nurses as outlined below.[21]

> *The current systems for health funding in Australia create serious barriers to effective health promotion and chronic disease management, and limit effectiveness in terms of equity, access and value for money. Major reform is needed to achieve models of care that are based on the best available evidence; are efficient and cost effective; and provide for positive patient outcomes and sustainable service delivery. Funding models should support sound health policy designed to meet population needs.*
>
> *For registered nurses and nurse practitioners to work to the full scope of their practice in the delivery of primary health care services in Australia, historical, professional and potential legislative barriers must be overcome.*
>
> *Registered nurses are self-regulated health care professionals who provide care in collaboration with other health professionals and individuals requiring nursing care. Legislation and regulation guide nursing practice. Registered nurses, as qualified licensed professionals, are accountable and responsible for their own actions.*
>
> *Nurses are entitled to identify the nursing care which they are educated, competent and authorised to provide. Nurses are held accountable for their practice by the nurse regulatory authorities, whose role is to protect the public, as is the case for all other regulated health professions.*
>
> *As regulated health professionals, registered nurses are not 'supervised' nor do they provide care 'for and on behalf of' any other health care professional. Nurses acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups.*

Registered nurses are prepared for advanced practice through post registration education, and accept responsibility for complex situations which may encompass clinical, managerial, educational and research contexts. They provide leadership, initiate change and practise comprehensively as an interdependent member of the team. These nurses have particular breadth and depth of experience and knowledge in their field of practice. Where appropriate, these advanced registered nurses may seek authorisation or endorsement as a nurse practitioner.

The nurse practitioner role is differentiated by their expert practice in clinical assessment, prescribing, referral and diagnostics. These broader practice modalities are enshrined in state and territory legislation. While there are around 300 authorised or endorsed nurse practitioners in Australia, only around half of these nurses are employed in nurse practitioner positions and even less are practising to the full scope of their role. Some of the restrictions on nurse practitioner practice are the lack of positions, an inability for patients to receive subsidised medicines if prescribed by a nurse practitioner (as distinct from a medical practitioner) or rebates from Medicare for nurse practitioner services, limiting their practice and reducing patients' access to affordable, high quality health care.

Registered nurses and nurse practitioners are ideally placed to deliver primary health care in Australia. Nurses in primary health care will not replace other health professionals but will (and do) provide a unique service that they are already well prepared and qualified to offer. Extending this service will enable the community to access a level of primary health care that is currently not available to the Australian population.

There is urgent need and immense benefit in reforming primary health care in Australia to optimise the expert and effective roles of nurses. There is strong potential not only to deliver improved health outcomes for the community, but also to impact positively on national productivity through the best employment of nurses - the largest professional health workforce in the country.

Our enhanced vision for the delivery of primary health care to the Australian population requires the acknowledgement at policy level of the capacity for professional nurses to make autonomous decisions. In addition, equitable funding mechanisms must be developed to facilitate the increased deployment of registered nurses and nurse practitioners in primary health care services and for the community to have access to subsidised medicines and services provided by nurse practitioners.

The ANF calls on the External Reference Group to take note of the issues raised by the nursing organisations who developed the Consensus statement, in their deliberations to effect sound reforms for the enhanced delivery of primary health care in this country.

3. Response to Discussion Paper

The ANF supports the view that there is a dual benefit to be gained from embedding a well established primary health care sector within the country's approach to health care: reducing the demand on the acute sector while at the same time improving health outcomes and population health and wellbeing.[22] It is in the context of the philosophy and practice of nursing as outlined in the preamble above that comments are made in response to the NPHCS External Reference Group's Discussion Paper, *Towards a National Primary Health Care Strategy.*

3.1 Discussion Paper Objective 1: All Australians have access to required primary health care services, which are clinically and culturally appropriate to their needs and circumstances, and are delivered in a timely and affordable manner

Discussion Paper Questions:

- How can we ensure appropriate services for all geographical areas and population groups?
- How could primary health care services/workforce be expanded to improve access to necessary services?
- What more needs to be done for disadvantaged groups to support more equitable access?
- With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?

Commentary

With reference to the *Code of Ethics for Nurses in Australia*[23] nurses place much importance on contextualising the care they deliver as encapsulated within the first value statement of the *Code* in relation to the community:

> *Nurses, individually and collectively, participate in creating and maintaining ethical, equitable, culturally and socially responsive, clinically appropriate and economically sustainable nursing and health care services for all people living in Australia. Nurses value their role in providing health counselling and education in the broader community. Nurses, individually and collectively, encourage professional and public participation in shaping social policies and institutions; advocate for policies and legislation that promote social justice, improved social conditions and a fair sharing of community resources; and acknowledge the role and expertise of community groups in providing care and support for people. This includes protecting cultural practices beneficial to all people and acting to mitigate harmful cultural practices.*

The nursing and midwifery workforce is currently an under utilised resource in the primary health care arena. This is due either to restrictions on scope of practice or lack of recognition of role and function of nurses and midwives. The ANF considers that there needs to be a much better utilisation of the nursing and midwifery workforce in order to ensure appropriate services for **all** geographical areas and population groups. Nurses tend to be the largest health care professional group across geographical areas - and in fact may often be the only health care professionals in remote areas. The Australian Government's Productivity Commission Research Report *Australia's Health Workforce*[24] provides a stark revelation of the fact that, unlike all other health professionals, nursing and midwifery numbers remain fairly constant relative to population for communities located further away from the major cities. While nurses and midwives in all areas can and do provide primary health care, the health promotion and prevention component of that care must often be minimalised due to lack of funding support and recognition of its importance.

To better meet the needs of the community in all geographical areas (metropolitan, regional, rural and remote) and across all population groups, (especially those currently marginalised from, and under-served by mainstream health services, such as the homeless), legislative changes are required to enable nurses to extend their current scope of practice. In particular, current policies in relation to access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme (MBS) by nurse practitioners, registered nurses (such as general practice nurses and community nurses), and midwives, mean that the practice of these nurses and midwives is restricted. Patients are grossly inconvenienced and inefficiencies and duplication of services occur. For example, a sexual health nurse practitioner in the ACT assesses a client, uses her experience and expertise to accurately diagnose and recommend the most appropriate treatment. However, as this particular treatment can only be prescribed under the PBS, and as she doesn't have access to subsidised PBS items, she can prescribe the best known treatment for the presenting condition but the client must pay the full amount for the medicine and cannot receive the government rebate. The client must have a separate appointment with a medical practitioner to receive the subsidised medicine. This is inefficient and a barrier to access to health care.

The National Health and Hospitals Reform Commission (NHHRC) interim report *A Healthier Future For All Australians*[25] recommends the reform directions (14.2 & 14.3) that Medicare rebates and PBS subsidies be expanded to include nurse practitioners, however, only to those working in rural and remote areas. The ANF position is that nurse practitioners have proven competency to practice in all settings and this restriction will disadvantage metropolitan and regional communities. The ANF will be lobbying strongly for the NHHRC to reconsider this flawed recommendation. The ANF calls on the NPHCS External Reference Group to develop funding models which will provide greater access to the range of health care professionals engaged in primary health care settings.

In addition to equipping nurses, midwives and allied health care professionals with the funding mechanisms for improving access to necessary services for communities, there is also room for expanding on services which can be taken to population groups. There have been examples around the country where nurses, either alone or with other health professionals, have provided services to people who would not normally access general practices or tertiary facilities. These groups include Indigenous communities, non-English speaking background (NESB) immigrant and refugee groups, the homeless, and sexual health workers. Effective interventions have been instituted such as screening tests, vaccinations, diabetic testing, antibiotic therapies and antenatal care. Some of these outreach services are only operational for the life of a specified funding cycle, for example the 'Street' nurses in the ACT in the 1990s. Ongoing funding has not been forthcoming despite demonstrated positive outcomes for the client base. Another example is the McGrath Breast Care nurse practitioners who are funded by donations, when clearly an ongoing need has been identified.

Funding models for primary health care must encompass static services - to which the community goes, and itinerate/outreach services - where nurses, midwives and other health professionals take their services to people and attend to their health needs in their own environment.

Another aspect of improving access for communities, especially for Indigenous and NESB population groups, is to provide financial and mentoring support for people from these groups to undertake education programs to become qualified health professionals. While there are some Australian Government scholarships available specifically to assist Indigenous students across health professional disciplines, there is strong evidence from the demand for these that more funding is required. Other measures to support more equitable access for disadvantaged groups include: improved funding for interpreter services for Indigenous and NESB populations; increased funding for literature and signage in health and aged care facilities in multiple languages; improved funding for inclusion of cultural awareness programs in undergraduate and postgraduate curricula for health professionals; and support for community leaders of Indigenous and NESB populations groups.

Recommendation

That to better meet the needs of the community, Medicare rebates and Pharmaceutical Benefits Scheme (PBS) subsidies be expanded to include appropriately qualified nurses and midwives for practice in all settings.

3.2 Discussion Paper Objective 2: PHC services respond to the individual preferences and circumstances of patients, their families, and carers, and actively support them in achieving best possible health outcomes

Discussion Paper Questions:

- What is needed to improve the patient and family-centred focus of primary health care in Australia for:
  - Individual patient encounters;
  - Heath professionals;
  - Health service organisations;
  - The broader primary health care system?
- Are there specific strategies that are needed to better support consumer engagement and input?

Commentary

Improvements to the patient and family-centred focus of primary health care in Australia require a care co-ordination and team based approach.

It is the view of the ANF that focussing on the health care needs of a community, with new initiatives aimed at preventing ill health, delays in treatment and unnecessary hospitalisation, will deliver effective reform in the health system, with particular benefit for primary health care.

Initiatives could include nurse-led or midwife-led clinics, funded to order diagnostic tests or prescriptions for the community, or clinics that have a range of health professionals working together, such as the Comprehensive Primary Health Care Centres proposed by the NHHRC.[26] The ANF sees merit in the concept of a 'one-stop' multidisciplinary primary health care centre which rationalises equipment, infrastructure and personnel and thus makes better use of scarce health care dollars. More importantly, there is easier access for the community to a range of health care professionals.

This model allows for:

- greater co-ordination of care, leading to greater satisfaction for both health professionals and the community and better outcomes of care,
- enhanced collaboration between health professionals, leading to professional support in clinical judgements, improved opportunities for interdisciplinary education and continuing professional development, greater opportunities for collaborative research to improve services and clinical outcomes,

- a decrease in duplication of services, meaning that health professionals are contributing to better utilisation of their services, more efficient use of resources and thus the health care budget,[27] and
- greater access and equity for effective health promotion and chronic disease management.

The ANF maintains that the key to providing better access for the community to primary health care services is the development of funding models in which the funding follows the person and not the provider/hospital (as in the current fee for service model).

The input of the community, based on their particular needs, the monitoring of community health status and the fostering of innovation and sharing of research, are critical to developing appropriate models of care, improving services and the health of the people in that community.

Services and care need to be based on the best available evidence and delivered by the most appropriate health professional or worker. Effectiveness of primary health care demands a culture of reflective improvement and innovation and a continuous cycle of development and implementation of health services research to constantly inform the development of health policy and increase the effectiveness of health service delivery.

There needs to be a balanced and effective use of both public and private resources. New technologies should be evaluated in a timely manner, and where shown to be cost effective, be implemented promptly and equitably.

Measures to improve the engagement and input from consumers of health care include the investment in innovations such as tele-health, e-health, and other means of providing information, support and access to primary health care services. It is especially important to make these measures and primary health care teams available to people disadvantaged by geographic, socioeconomic, or cultural isolation, health status and disability, to minimise this isolation and maximise their capacity to maintain or restore their health.[28]

Including consumers of health care services in the primary health care setting in decision making at all levels is paramount to gaining input to the development and ongoing evaluation of these services. A process for genuine consultation must be instituted which allows for equal representation of consumers along with health professionals, on decision making bodies/committees. This entails orientation and information sharing so that maximum value can be gained from consumers' and health professionals' contribution and so that all parties feel that their view is being respected. Consumer representatives will require funding and education support. There needs therefore to be a sustainable funding investment to enable full participation in these activities by all parties.

Other strategies for engaging with consumers of the services include:

- involving community groups in discussion around their service needs,
- formal information gathering processes, such as consumer satisfaction surveys,
- establishing community forums,[29]
- funding for primary health care workers such as registered nurses and midwives to take and market their services, for example, counselling for rural communities, and
- involving consumers in the analysis of data received from consumer surveys.

Recommendations

That there be a focus on the health care needs of the community, with new initiatives aimed at preventing ill health, delays in treatment and unnecessary hospitalisation, to deliver effective reform in the health system, with particular benefit for primary health care.

That to provide better access for the community to primary health care services, funding models be developed in which the funding follows the person.

3.3 Discussion Paper Objective 3: All Australians are supported to stay healthy through a stronger focus on wellness, prevention and early detection, and appropriate intervention to maintain people in as optimal health as possible

Discussion Paper Questions:

- How could primary health care be enhanced to better support prevention activities?
- How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?
- How can consumers be linked with local PHC services to support a stronger focus on population-based preventive health care with national reporting?
- What measures have been, or could be effective in addressing prevention for specific population groups (Indigenous, rural and remote, low socio-economic status, CALD)?
- With limited public health dollars, how could preventive care priorities be determined and public resources subsequently targeted?

Commentary

It is the view of the ANF that the role of primary health care services provided locally, by community health providers including general practices, should not be underestimated. There is a need for a fundamental shift in the focus of health care, encouraging prevention, early intervention, and direct easy access to appropriately qualified and skilled health care professionals.

This is currently being done by nurses in some sectors, for example, school nurses, general practice nurses, maternal and child health nurses, and especially in rural communities. This work needs acknowledgement, encouragement and, most importantly, flexible funding.

Policy development and provision of health services needs to be shaped around the promotion of healthy living, the prevention of disease, injury and disability; as well as meet the health care, treatment, self management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care across the period of their lives.[30]

In order to ensure that policies and processes are appropriate for communities it is important to remember that people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[31] Integral to this process is the involvement of both community members and health professionals as to their views on indicators of population-based preventive health care and thus what should be included in national reporting.

The legitimacy and sustainability of major primary health care policy decision depends on how well they reflect the underlying values and views of the community. Community engagement and participation requires the opportunity for the community as well as nurses, midwives and other health providers and managers within the health sector to assess evidence and develop and implement plans to improve health and health care.

Strategies to achieve community participation in the development of health policy, health services and in their own care recognise the often disempowered nature of people's relationships with health care providers in a health system that is highly complex and confusing and requires support for building the capacity of persons to be involved in their own health care.[32]

Nurses, midwives and other health professionals employed in primary health care settings need to have funding support which enables them to undertake clinical loads as well as health promotion/education and research loads. Health care managers must be respectful that time is built into the working life of primary health care professionals for them to be able to meet with population groups to discuss lifestyle modification options and to listen to concerns and barriers to achieving a healthier lifestyle. Investment in

time to assist people become more self-reliant and better able to manage their own health care needs, will have positive outcomes for the health system as a whole and the community if hospitalisations can be avoided and/or chronic diseases/disabilities be better managed.

Nurses and midwives already have well developed networks within communities and population groups to undertake opportunistic primary health care. Examples include diabetes management, immunisations or sexual health screening among Indigenous and rural and remote communities, health promotion sessions in senior citizens clubs, coffee mornings with young mothers in community health settings especially those from low socioeconomic areas. A mapping of examples such as these could be undertaken to provide exemplars for adoption across the country in primary health care settings. Again, it is imperative that these activities be incorporated into funding models for primary health care. While it may take some time to develop, the community should start to see a shift in health expenditure from tertiary to primary health care, and perhaps also, ideally, better utilisation of the health budget in terms of a sustainably healthy society.

There are currently in excess of 27,000 nurses and midwives in Australia employed in a variety of roles providing health care for the community across the lifespan within a primary health care setting.[33] However, it should be noted that data collection with regard to these roles is inadequate and actual numbers may be greater.

Primary health care nursing and midwifery roles include registered and enrolled nurses, midwives and nurse practitioners working as maternal and child health nurses, general practice nurses, community health nurses, school nurses, occupational health nurses, rural nurses, remote area nurses, sexual health nurses and mental health nurses.

The following is an overview of the scope of practice of some of these roles:

Maternal and child health nurses - registered nurses, and in many instances midwives, with additional qualifications in Maternal and Child Health and Community Health. They offer a range of services in their practice through individual consultations, home visits and group meetings; provide health education to families to promote health and wellbeing and prevent illness; offer support and guidance to families while developing parenting skills; assess child growth, development and behaviour at key ages and stages; guide and inform families in relation to family health, breastfeeding, immunisations, nutrition, accident prevention and child behaviour; and provide access to information on child and family services. There are 5,276 nurses working in the area of family and child health. The majority of these nurses are employed in New South Wales, Victoria and Queensland.[34]

General practice nurses - registered and enrolled nurses employed by, or otherwise retained by, a general practice. Almost 5000 general practice nurses were estimated as employed in general practice in 2005 and more than half (57%) of general practices were reported to employ a practice nurse. Anecdotally this figure has now risen considerably to around 8,000 nurses in 2007.[35] Practice nurses work in collaboration with general practitioners, providing a range of primary health care services, including chronic disease management, population health activities, health assessments such as the Healthy Kids Check, administer and provide advice about immunisations, identify and provide education with regard to risk factors for chronic illness, provide health education, and monitor the effectiveness of education and other strategies.

Primary school nurses - provide a primary health care service to primary school aged children (5-12 years of age) and their families. Primary health care services encompass a range of services directed towards health promotion and information, early identification and early intervention for identified health concerns. School nurses engage in clinical care, health counselling, health promotion, school community development activities, networking/resource and referral and general health centre management. They provide specific health surveillance activities for children at school entry as well as health assessments for all school entrants, and for any students referred by a parent or teacher. In addition to vision screening and hearing testing, health promotion and education activities such as immunisation, safety and injury prevention, nutrition, positive parenting and asthma management are undertaken as group sessions through daily contact with students, teachers or parents.[36]

Secondary school nurses - have a key role in reducing negative health outcomes and risk taking behaviours among young people including drug and alcohol abuse, sexual behaviour, smoking, eating disorders, obesity, depression, suicide and injuries. The role specifically encompasses individual health counselling; health promotion and planning; school community development activities; small group work focusing on health related discussion and information; and a resource and referral service to assist young people in making healthy lifestyle choices. They play a major role in health promotion and primary prevention.

Community health nurses - a combination of nursing practice, public health practice, health promotion and primary health care. They work with their local communities to prevent illness and promote health, across the lifespan, through the identification of barriers to wellness and the empowerment of people to change unhealthy lifestyles. Through working in partnership and recognising the actual and potential strengths of families and communities, community health nurses seek to foster a sense of self-determination and empowerment of clients. The AIHW survey indicates that there are 13,926 nurses employed in the area of community health, which may also include those employed as school nurses and occupational health nurses.[37]

Occupational Health Nurses - provide for and deliver health and safety programs and services to workers and community groups. This area of nursing practice focuses on promotion and restoration of health, prevention of illness and injury and protection from work related and environmental hazards. They have an integral role in facilitating and promoting an organisation's on-site occupational health program. Their scope of practice includes disease management, environmental health, emergency preparedness and disaster planning in response to natural, technological and human hazards to work and community environments. Occupational health nurses provide specialist health and safety advice and administer Injury Management, First Aid and Emergency Preparedness Programs; as well as develop provide health education programs, such as exercise and fitness, nutrition and weight control, stress management, smoking cessation, breast and testicular self examination, management of chronic illnesses and effective use of health services.

The ANF supports the NHHRC reform directions in relation to the health and wellbeing of children. In particular:

Reform direction 3.8

We propose that all primary schools have access to a school nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.

Reform direction 3.9

We propose that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure continuity of care and a comprehensive understanding of a child's health needs…[38]

It is critical that primary health care interventions commence at the start of a child's life, are built on through the developing years, with reinforcement throughout school life. The role of parents in developing children's attitudes, habits, and lifestyle behaviours is of paramount importance. Strategies that focus on shared goals between primary health care providers and parents are essential for long term success. Currently, child care centres/kindergartens/schools and primary health care settings do not provide the services needed for behavioural change. Although population health strategies in both schools and communities are vital to their effectiveness, reach and sustainability must be improved to reduce the prevalence of non-communicable diseases in children in this country.

Recommendations

That there be a fundamental shift in the focus of health care, encouraging prevention, early intervention, and direct easy access to appropriately qualified and skilled nurses, midwives and other health care professionals, within primary health care services provided locally.

That there be input from both community members and health professionals in the planning and implementation of their health care.

3.4 Discussion Paper Objective 4: All Australians, particularly those with multiple, ongoing and complex conditions, experience PHC services which are coordinated across multiple care providers, with transitions across health sectors actively managed and continuity of care supported

Discussion Paper Questions:

- What target groups would most benefit from active clinical care and/or service coordination?
- Who is best placed to coordinate the clinical and/or service aspects of care?
- How could information and accountability for patient handover between settings (eg hospital and general practice) be improved?
- What changes are needed to improve integration between different primary health care organisations?
- Would there be advantages in patients having the opportunity to 'enrol' with a key provider?

Commentary

All sectors of the community would benefit from improved lines of communication between the different sectors of the health and aged care system. However, while many people are able to utilise their informal networks to navigate their way around the complexities of our primary and tertiary systems, or have a significant other who can assist them with this, for some particular groups the whole process is incredibly daunting.

Target groups who would most benefit from active clinical care and/or service coordination include people for whom English is a second language (and this includes many of our Indigenous communities), those with a low socioeconomic status (especially young mothers who have no form of transport), those with severely debilitating chronic conditions or disabilities, and frail, elderly people (particularly those who live alone). For most of these groups, not only is it difficult to understand where they should enter the health care system, it is also nigh impossible to actually physically get themselves to a health professional due to transport/language/cost obstacles. People who do not have a family member or friend who can act as an advocate on their behalf to help them navigate the health system are currently 'falling through the cracks' leading to compromise of their care.

The NHHRC interim report carries an exemplar of a model of primary health care involving a community hub.[39] Within that model:

> *Two general practice liaison nurses employed by community health (one for chronic, aged and complex care; and for child and family) are linchpins of the model as they identify clients needing care coordination and link GPs and other service providers.*

As stated previously nurses form the largest single component of the health workforce. As such the ANF considers that they are well positioned to undertake the clinical care coordination role so desperately needed across the country, both within the primary health care sector, and to liaise between primary and tertiary settings. Nurses are educationally prepared to provide a holistic view of a person in their everyday practice, taking into account the broader context of that person's environment and how that impacts on their health status. This type of approach means that they are well tuned to be able to consider the total care needs for a person including their physical, social, spiritual and mental health needs. Liaison with a range of care providers forms part of the current role of most nurses in their clinical care and could become a recognised and established part of a primary health care nurse's role. The ANF cautions that this aspect must be built into a primary health care nurse's job description and funded appropriately so that their role receives due acknowledgement and time allocation.

Improvements in information transfer between different sectors of the health and aged care arena can be achieved through financial investment in integrated electronic systems. Ready access for all health professionals employed in primary health care settings to email, internet, records management systems, and patient history records systems, is essential for timely and safe health information management.

The ANF supports the implementation of an individual electronic health record system to facilitate rapid transfer of information across public and private facilities, primary, secondary and tertiary health care; and to provide a greater degree of transparency of a person's health records to all parties involved in that person's care - especially the person themselves! The introduction of an individual electronic health record system would assist in overcoming current integration difficulties across the acute/community divide such as:

- lack of information provided with referrals,
- not enough time between the referral and when care needs to commence, and
- lack of knowledge within the acute setting in relation to available community services.[40]

The ANF supports the concept of 'enrolment' in primary health care centres, however, with caution that there be flexibility to ensure that health care service needs are met. It is critical that patients still have a choice and that health care can be provided when they are not at home for those who travel.

Recommendations

That the implementation of an individual electronic health record system be expedited by the Government to facilitate rapid transfer of information across public and private facilities, primary, secondary and tertiary health care; and to provide a greater degree of transparency of a person's health records to all parties involved in that person's care.

That nurses and midwives are consulted in the development and implementation of health informatics.

That funding be provided for the existing workforce of nurses and midwives to undertake the necessary education to meet the Informatics Competency Standards required for nursing and midwifery practice.

3.5 Discussion Paper Objective 5: All Australians have access to safe, high quality PHC services that deliver evidence-based care and accountability for outcomes, support continuous quality improvement, and reward research and innovation

Discussion Paper Questions:

- What aspects of performance of the primary health care sector could be monitored and reported against (eg for each Element in this Discussion Paper, what are key areas of performance that could be monitored and how)?
- Who should be responsible for developing and maintaining a performance frame work?
- Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals?
- How can we improve the current research culture and evidence-base in primary health care?
- How can we translate evidence or innovation into practice more systematically?
- What options could be used to support health care professionals' involvement in research and innovation?

Commentary

The evidence of the performance of the primary health care sector will be seen in how well holistic care programs have been established and the links to population health care demographics for the particular community (some elements may change from community to community). Hence, there should be a demonstrated link between clinical care programs and the broader social context of the community - for example, housing education, support provided in the home and, nutrition programs.

Key areas of performance that could be monitored include (but are not limited to):

- demographics of the community and needs analysis of health care issues,
- types of programs offered through the primary health care centre, and how the needs link with the programs offered - such as, evidence of holistic care programs for population health care demographics (so this will change from community to community): antenatal, postnatal, early intervention, schools, health promotion, health prevention, chronic disease management, rehabilitation and aged care,
- evidence that health is being considered with the social determinants of the community - for example, housing, employment, education, nutrition, support in the home needs,
- satisfaction surveys of population groups to determine if specific needs are being met,
- evaluation of return trips to the centre - whether for unresolved issues or ongoing care,
- registers and recall systems established for chronic disease management such as diabetes; screening; immunisations - depending on needs of community,
- if enrolment system used - percentage of population in the catchment area enrolled (in other words who is missing from the catchment area), and
- outcome measures

Funding needs to be provided for software which will enable consistent data collection across jurisdictions for reporting at that level and also to be able to migrate into data systems at the national level. Ideally, then, the elements for data collection need to be agreed initially at a national level to facilitate this consistent approach.

A performance framework is a good approach to ensuring consistency in the evaluation process. The principles need to be set up by a national primary health care body, then applied to local communities by a stakeholder group.

There are advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals. This approach gives positive reinforcement for work undertaken to improve the health of the different population groups within the identified catchment area for the primary health care centre. Incentives could also acknowledge different aspects of the work being undertaken by different disciplines/specialty groups within the team.

It is imperative that there be investment in research to provide evidence on which to develop improved models of primary health care. Research must be designed to obtain evidence both nationally and internationally, that is sensitive to the particular health needs of the population group/community being studied. This recognises the diversity of primary health care needs and the variety of models of care that may be appropriate to different communities or sub-groups of communities.

Funding models need to include time for clinicians of all disciplines to carry a clinical load and have allocated time for research activities - literature searching including systematic reviews; time for collecting and collating data, analysing data, funding for contracting out aspects of work if required, writing up results, publishing, speaking at conferences to disseminate research. There are two aspects to research application which need consideration - either implementing research findings of others for example, the National Institute of Clinical Studies work, or other primary health care centres work, or implementing findings of own research.

Also, funding must be provided for research, education and ongoing continuing professional development of health care professionals. There must be acknowledgement of the equal value of both qualitative and quantitative research in supporting clinical practice.

Funding models need also to include the ability for primary health care centre health professionals to mentor novice researchers coming into the centre. Likewise, funding models should include the facility for consumers of the care of the primary health care centres to participate in research.

Recommendations

That there be funding invested in research to:

- provide evidence on which to develop improved models of primary health care,
- support nurses, midwives and other health professionals to undertake clinical loads as well as a research load,
- provide for research education and ongoing continuing professional development in research for nurses, midwives and other health care professionals,
- include the ability for primary health care centre health professionals to mentor novice researchers, particularly undergraduate nursing and midwifery students, and
- include the facility for consumers of the care of the primary health care centres to participate in research.

3.6 Discussion Paper Objective 6: PHC services arrangements benefit from greater sharing and improved access to health information, clinical knowledge resources and emerging technologies to better support patient-centred care

Discussion Paper Questions:

- What is the role for eHealth in supporting the provision of quality primary health care?
- Where should the Government prioritise its actions in relation to implementing eHealth reform?
- How can the various information systems be integrated (eg state health services and General Practice)?

Commentary

There is a critical role for eHealth - in this era of widespread use of electronic information systems, the use of eHealth is fundamental to primary health care. Health care professionals require access to information in a timely manner and consumers of care need to know that these professionals have access to this information, for example, most recent tests/procedures/consultation remarks so that visits can be conducted efficiently for both parties.

Ehealth means that health care professionals can keep up to date with the latest evidence and the whole gamut of issues presented by clients; consumers of primary health care services can remain informed if they so wish to, or be encouraged to do so. Transfer of information is rapid and timely, with an increased chance of consistency in information when coming from the same/similar source for all parties. Web-based information allows health care professionals to direct clients to particular sites for information, either through use of computers set up in the primary health care facilities or to refer to at home. Individual electronic health records (IEHR) mean that people don't have to rely on their memory each time they visit a health care professional regarding previous history, medicines or treatments. Access to the same information via the IEHR should lead to a significant reduction in gaps which frequently occur now in client treatment. Everyone is able to review the same information and consider what others have decided/ prescribed thereby reducing duplication of tests/medicines ordered, reducing the dollars spent in the health care system and reducing time wastage and inconvenience to clients and their carers.

There are significant benefits if tele-health were to be instituted in an extensive manner in that health care professionals in rural and remote areas could tap into consultations with specialist clinicians - that is, all disciplines in the primary health care centre/field, to greatly assist in clinical care and thus better outcomes for clients.

It is suggested that an approach to prioritising actions by the Government be the implementation of IEHR, building computing capacity in primary health care settings for all health care professionals, and instituting hand held computer capability for field workers.

It is imperative that primary health care computer capability be fully integrated with tertiary services, to enable timely access to, for example; patient discharge records, tests/treatments and secondary services to gain access to pathology or radiology results, and with local pharmacies for convenient prescribing.

Crucial to the full scale introduction of eHealth systems into primary health care is attention to building computer literacy capacity amongst health care professionals. In July 2007, the ANF released the results of a study of 10,000 nurses in Australia on their use of information technology in the workplace. The study clearly identified that nurses recognise benefits to adopting more information technology in the workplace although there are significant barriers to their use. The study showed that: nurses are frustrated by limitations of access, software that is not always fit for purpose, and lack of opportunities for training; the level of use of information technology is generally low as is confidence, even among those nurses who are users (the aged care sector scored the lowest on all parameters studied); there is evidence that familiarity, use and confidence in use is slightly higher in nurses who have recent tertiary education; nurses believe they are poorly informed about information technology health initiatives and poorly consulted about the implementation; almost two thirds of nurses had not received any formal training in basic software applications and of the 90% of nurses who used computers or other information technology applications, only one third had any formal training. The principal barriers to the use of information technology was seen to be workload, number of computers, inadequate technical support (especially poor in more remote locations) and lack of training. Nurses believed that the full potential of information technology use in the provision of health and aged care would not be realised until the limitations as outlined above are addressed.

We know from this study that there is a gross deficit in the capacity of the nursing and midwifery workforce to engage in the digital processing of information. It is essential for nurses and midwives beginning practice to have basic computer skills and competencies in nursing and midwifery informatics; in particular, they should understand the importance and use of clinical information systems in their practice, as well as have skills in the manipulation of data to support safe and informed practice. It is also necessary for more expert nurses and midwives to engage in these activities at more advanced levels.

Currently, funded research is being undertaken to inform the development of national information technology competency standards for nurses which will be incorporated into all undergraduate courses. Governments and employers should consult with nurses and midwives when planning new information technology initiatives; provide 24 hour technical support; and provide all nurses and midwives with access to the internet at work.

Recommendation

That primary health care computer capability be fully integrated with tertiary services, to enable timely access to, for example, patient discharge records, tests/treatments and secondary services to gain access to pathology or radiology results, and with local pharmacies for convenient prescribing.

3.7 Discussion Paper Objective 7: PHC services in Australia operate with an accountability and governance framework which is responsive to local needs, and is sustainable, flexible and well integrated with other non-health services in local communities

Discussion Paper Questions:

- How could planning for primary health care services at the local level be improved?
- What advantages/disadvantages would there be in having a regional organisational structure with responsibilities (ranging from local planning through to service delivery) for primary health care services?
- Who could undertake this role? - What changes would be needed to existing organisations (eg Division of GP, Area Health Services) to undertake this?
- What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care service for their communities - that is, should they 'hold funding' for health services?
- What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?
- How can greater community engagement be supported in primary health care?
- What other approaches could improve planning and service integration at the local level?

Commentary

Planning for primary health care services at the local level will be improved by involving all stakeholders - health care professionals, managers, community members, voluntary service representatives, local councils. There must be commitment from local communities to sustain the efforts of primary health care programs and to achieve positive health outcomes, and this commitment can only be obtained through their full involvement.

The greatest advantage in having a regional organisational structure with responsibilities is that the responsibility level is close to the centre of operation of primary health care services, thus increasing the transparency of accountability to the community.

The disadvantage is the risk of lack of consistency in governance of primary health care services across the country; which produces difficulties in standardising data collection for trend information to guide policy formulation which underpins primary health care services; which leads to a risk of continuation of fragmentation of services across jurisdictions.

While the Division of Primary Health Care notion has merit the ANF cautions against this being an extension of the existing Divisions of General Practice. There is a perceived risk of a strong influence then of general practitioner driven care as opposed to primary health care. In order for the new model to achieve the desired outcomes of primary health care the focus must encompass the broader principles and practice, than the narrower focus of general practice.

3.8 Discussion Paper Objective 8: PHC professionals work in environments which support a team-based approach and a work/life balance, with conditions that attract, support and retain a strong local workforce

Discussion Paper Questions:

- What changes in working arrangements and conditions will better support primary health care professional?
- How is teamwork facilitated in primary health care services and between them?
- How could the general practice nurse role be developed and enhanced?
- How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?
- Are there specific changes needed into those regions or populations where there is difficulty attracting and retaining staff?
- What funding arrangement could best support team-based care?
- How is it determined who is best placed to lead in multi-disciplinary team arrangements?
- Are other changes needed to current roles and responsibilities (eg for prescribing and referral rights to be extended to non-GPs and specialists?

Commentary

At present general practice nurses can only access certain MBS items under a 'for and on behalf' of model. The ANF calls on the External Reference Group to recommend that this arrangement be removed so that nurses in general practice and in other primary health care environments are able to provide comprehensive care to their patients.

Nurse practitioners should provide care for a designated population group for example, aged care either in the community or in residential aged care facilities or across both areas: manage diabetes, respiratory conditions, and cardiac disease; and cover the whole sphere of care from health promotion/prevention/early intervention issues to acute episodes of care providing triage and referral, to chronic disease management.

Presently it is predominantly only medical practitioners who receive incentives for working in regions or populations where there is difficulty attracting and retaining staff. These measures should be available to health care professionals across the board. This issue is discussed under 3.10.2.

Health professionals are increasingly expected to function in a multidisciplinary environment. The overall concept embedded in multidisciplinary teams is that of an inter-professional, collaborative approach to health service provision.

Future careers in nursing and midwifery are likely to see a continued emphasis on collaboration, and greater recognition of the value and efficacy of care delivered by multidisciplinary teams. For the future primary health care system to provide equitable access to cost effective care that delivers the best possible outcomes, much will depend on the successful establishment of collaborative relationships among all the health professions, and an increased emphasis on the delivery of care by multidisciplinary teams.

The team concept assumes that the problem being addressed is so complex that no one discipline alone possesses the expertise or information to provide all care. In a smoothly functioning multidisciplinary health care team, services are provided by an integrated group of professionals who coordinate health care services across a variety of disciplines. The team members work well together and believe that the combined contribution of the team is greater than any one discipline can provide. Team members from different disciplines work independently, collectively setting goals and sharing resources and responsibilities.[41]

Organisational psychology research has found that effective health care teams can: reduce hospitalisation and costs; increase effectiveness and innovation; increase wellbeing of team members; deliver higher quality patient care; lower patient mortality; reduce error rates and reduce turnover and sickness absence.[42]

To be effective these teams need: shared goals (including a commitment to the best use of team members skills to reduce duplication of services); recognised interdependence including awareness of the skills and knowledge each member has to contribute to the team; clearly defined roles and responsibilities of team members; mutual respect and trust amongst team members; identifiable and approachable team leadership; shared power and decision-making and shared accountability for outcomes; adequate time for team building and communication between members; adequate physical resources; compatible financing arrangements for team members; and clear benefits from participation in teamwork.

The most appropriate health care professional at the time should take the leadership role. This will change depending on the circumstances - it could be the nurse, midwife, medical practitioner, or an allied health professional. In an interdisciplinary team, members work together interdependently to develop goals and a common treatment plan, although they maintain distinct professional responsibility and individual assignments.[43]

Aspects of funding in relation to nurses, midwives and nurse practitioners is dealt with in 3.1 above, regarding necessary changes to legislation to enable access to PBS and MBS. For there to be effective team work in the primary health care sector the ANF contends that prescribing rights must be opened up to non-medical health care professionals. Another area of restriction which must be given attention by the External Reference Group is to remove the current 'for and on behalf of' policy governing some MBS items. The result of this policy is that nurses, midwives and nurse practitioners are hampered in their ability to provide comprehensive care and this significantly reduces the efficiency of primary health care delivery.

Recommendations

That additional funding is provided to universities to ensure undergraduate nursing and midwifery courses:

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

That for there to be effective team work in the primary health care sector the following changes be made to policies and legislation governing the Medical Benefits Schedule (MBS) and PBS to allow:

- prescribing rights for appropriately qualified nurses and midwives, and
- the removal of the current 'for and on behalf of' restriction for nurses and midwives in the MBS.

3.9 Discussion Paper Objective 9: The current and future PHC workforce is provided with high quality education (undergraduate, postgraduate and vocational) and clinical training opportunities that support interdisciplinary learning

Discussion Paper Questions:

- What improvements are needed to primary health care education and training? For example:
  - How can innovative vertically and horizontally integrated teaching models in primary health care be encouraged?
  - How can the role of teaching be better supported in a sustainable way?
  - How could inter-disciplinary learning be better supported and provided in a more sustainable way?
  - Is there a greater role for competency-based education?
  - What incentives could be offered to trainees to make settling in high needs/work force shortage communities more attractive?

Commentary

With regard to interdisciplinary learning, health care professionals need to be better supported to undertake learning across disciplines within the educational environment. One element of this is to support the nursing and midwifery professions in their effort not to allow undergraduate programs of nursing or midwifery to be conducted outside the university sector. Other health care disciplines with whom nurses interact in their daily practice are educated within the university sector and the nursing and midwifery professions must not be marginalised from mainstream health care professional education.

The nursing and midwifery professions already have competency-based education embedded in undergraduate programs. Advanced practice competencies are embedded in specialty program education at post graduate level. These competencies provide a framework and a measure for ensuring that nurses and midwives undertake safe, competent practice, across the range of health care environments, including primary health care.

While the ANF welcomes the existing Australian Government funded scholarships, the number of available undergraduate and postgraduate scholarships is insufficient to have any significant impact on meeting the rural and remote nursing and midwifery workforce demands, the mental health nursing workforce, and nurse practitioner position requirements.

There are many more eligible applications from practising nurses and midwives seeking access to financial support for ongoing professional development and additional postgraduate qualifications than available funding.

Another issue with scholarships is that funds are distributed across a range of applicants; therefore an applicant may only receive a component of the full cost of undertaking an educational activity. The remaining cost has to be contributed by other means, including personal means, which impacts on the ability of many nurses and midwives to take up the scholarship at all.

There are ongoing difficulties for rural and remote area nurses and midwives in accessing ongoing education and professional development. The ability of nurses to attend educational events relates directly to the availability of appropriately qualified and readily available relief staff, as well as obtaining leave from their workplace.

Additional challenges to attend educational events include the distance to be travelled, inflexible learning environments, and unrealistic expectations relating to clinical practice and learning opportunities. Many nurses and midwives use valuable long service leave and holiday entitlements to attend courses. These issues continue to provide barriers for ongoing education.

Without sufficient scholarship funds to increase the number of nurses and midwives in remote and rural areas, and to cover the real costs associated with learning activities, whether for undergraduate education or for ongoing professional development, there is limited opportunity for nurses and midwives practising in rural and remote areas to obtain education.

Clinical placement funding and places need to be made available in primary health care settings for undergraduate health care professionals. Apart from the facility for medical students to undertake clinical placements in general practice, and for some nursing students to be placed in community health centres, there are generally too few opportunities for other health care professional students to be involved in primary health care settings across the broad range of areas in which this is practiced.

There are shortages in the numbers of available clinical placements for students in rural and remote areas and a lack of experienced staff who can supervise students. Students may be required to fund their own access to, and accommodation for the clinical placement, limiting access for those from other areas who may be interested in undertaking clinical placements in rural and remote areas.

Recommendations

That clinical placements for undergraduate nurses, midwives and other health care professionals be made available and funded across the full range of primary health care settings.

That increased numbers of Australian Government funded scholarships be made available for undergraduate and postgraduate nursing and midwifery students, and in particular, numbers of scholarships for nurse practitioners in primary health care settings.

3.10 Discussion Paper Objective 10: Discussion Paper Objective 10: All Australians have a primary health care system which is efficient, including making the best use of the available workforce, and is cost effective, fiscally sustainable for governments and affordable for individuals and families

Discussion Paper Questions:

- Are there other funding models for primary health care that need to be considered?
- How can we ensure that primary health care expenditure is sustainable?
- Should a new mechanism(s) be implemented to consider whether proposed new primary health care interventions should be subsidised?
- What should be an appropriate mix of public and private funding for primary health care?

Commentary

The current systems for health funding in Australia create serious barriers to effective health promotion and chronic disease management, and limit effectiveness in terms of equity, access and value for money in primary health care. In most instances, the community does not have much input or control in relation to health strategies that directly affect them. The models of promotion, prevention, care and treatment are not always based on the best available evidence. This leads to discrepancies in their efficiency and cost effectiveness; and the current modalities don't necessarily provide for positive outcomes for people and their communities; and sustainable, replicable service delivery remains a challenge.[44]

The ANF strongly supports funding models which provide for positive health outcomes for communities through sound health policy designed to meet population needs.

Funding for services, programs, care and treatment must be based on the population health needs of the community and be designed to promote the goals of primary health care enabling the promotion of health, maintenance of health, continuity of care and the involvement of a range of health care professionals in the care. This model allows for a person to be seen by the right health professional for their needs, in an appropriate place at the right time - that is, a needs driven funding model, not one driven by a

particular health care professional. This requires investment to create supportive environments and policies that promote and protect our health and prevent disease and injury in order to maximise people's potential to achieve optimal health.[45]

The ANF reiterates that the key to providing better access for the community to primary health care services is the development of funding models in which the funding follows the person and not the provider/hospital, as in the current fee for service model.

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

3.10.1 Models of care

There are many examples across the country of models of care which could be replicated on a broader scale to effect efficiencies both by utilising the most appropriate health care professionals, and by engaging with the community to ascertain the most appropriate solution to health or aged care needs.

Two models which the ANF supports and wants to highlight, are demonstrated exemplars of models of care that utilise the available workforce to provide comprehensive primary health care services in rural communities. These are outlined below for the benefit of the External Reference Group. The following examples fit well with the international Treaty of Alma Ata definition of primary health care which places health in the broader social context. The ANF believes this treaty is the essence of primary health care that we should be aspiring to in Australia.

Walwa Bush Nursing Centre in Victoria

Following the failure of their no-for-profit community Bush Nursing Hospital when funding ceased, the Walwa community rallied to establish a Bush Nursing Centre. It is built around a small health care workforce which includes a nurse practitioner, Sandi Grieve, and four nursing colleagues who together conduct a nurse-run emergency facility, and a General Practitioner, Dr Dave Hunt. The major features of the Centre are a community centre, used for training, meetings and functions; a gym for public use and nurse-run programs; a community vegetable garden; nursing and management offices that coordinate various allied health services, community services and health education programs; and nurses accommodation (a nurse stays overnight for on-call emergency work). Importantly the Centre is like a hub within the community in that the nurses go out into the community to visit elderly people, and the primary school children come into the Centre to learn healthy cooking and exercise, as well as using the facility for concerts. Initially the community raised funds towards the Centres establishment. Now, while funding is from state and federal government, the whole community works to ensure that existing programs and new initiatives are aimed at sustaining the Bush Nursing Centre, the medical practice and the community.[46]

The ANF maintains that this is a good model and that there should be funding from the government for more dedicated nurse practitioner positions to encourage the replication of this nurse practitioner-led model in other small communities.

Port Macquarie Aged Care in NSW

The following story was reported in the Australian Nursing Journal, Dec 08/Jan09 edition:[47]

The far north coast of New South Wales has one of the highest concentrations of older Australians, with a quarter of the population of Port Macquarie aged over 65 years.

It's here that Debbie Deasey works as a transitional (trainee) nurse practitioner treating the elderly in their homes and residential aged care facilities and keeping them away from the Emergency Department at Port Macquarie Base Hospital

Working from the hospital and with the help of her "very supportive" GP mentors, Debbie assesses and, where necessary, prescribes medication, which is then authorised through the GPs (this will change next year when she becomes an authorised NP).

"So if someone's aged over 70 and can't access their GP, I'll go out and help treat them for a variety of things, including pneumonia, infections, delirium or checking catheters."

A local girl who started as a hospital cleaner around 16 years ago, Debbie completed her registered nurse education before undertaking a Masters in Gerontology. She began work as a transitional aged care nurse practitioner in October 2007, and loves the choice it gives the elderly.

"The patient is safe, the staff are happy and it prevents an ambulance trip and an emergency presentation." The other patient benefit is a next day review of the treatment and the extra time Debbie can take as a nurse practitioner. "They like that one-on-one service - they can ask questions and I'm not as rushed as a GP."

"I'm also looking at the patients from a nursing perspective, so I take into account the family, the environment, medications and the education I can provide," she says.

"It also empowers the residential facilities by enabling them to get a nurse practitioner in straight away to take care of something simple like dehydration." Debbie would love to see more nurse practitioners working in aged care within residential facilities and in the community. But she says easing up the restrictions on PBS and MBS benefits access is crucial to this expansion.

* The NSW Department of Health has estimated Debbie's work has saved the hospital $1.5 million in hospital admissions for over 65s.

3.10.2 Funding incentives

Action is needed to ensure that the incentives available to rural and remote health professionals are equitable across the professions, in order to recruit and retain health care professionals. In many rural and remote settings, small numbers of people from a range of health professions work together in teams. Any inequity in the range of incentives that is available to each of the professions undermines the collaborative nature of multidisciplinary team work and should be reduced or eliminated where possible.

At present, there are significant inequities in the incentives available to nurses and midwives in rural and remote areas compared to those available to medical professionals. For example, many incentives are available for medical students to encourage them to consider a career in rural and remote health but few are available for rural and remote nurses and midwives. Given that rural origin is an important predictor of rural practice, more effort should be made to encourage rural students to consider a nursing or midwifery career and for those interested in a rural health career to have the opportunity to undertake rural clinical placements.

Other examples of inequitable incentives include the financial incentives available to doctors through the Rural Retention Program; support networks available to the families of rural and remote GPs through the Rural Medical Family Network; and funds available for training and locum relief. Facilitating leave for holidays, professional development, and other purposes for nurses and midwives requires the availability of adequate replacement staff. Many nurses and midwives report difficulty in accessing appropriate replacement staff, which affects their ability to take necessary and accumulated leave.

A comprehensive and consistent approach to education and professional development of nurses and midwives is vital to ensure the community receives care that it is competent and evidence based.

Recommendations

That incentives available to rural and remote health professionals are equitable across the professions, in order to recruit and retain health care professionals.

That there be an increase in funding for designated positions for nurse practitioners in primary health settings and especially in small rural and remote communities.

4. Conclusion

The ANF is firmly of the view that a well structured and well resourced primary health care sector should be central to this country's health care system. In keeping with the 1978 international Treaty of Alma Ata primary health care aspects of a person's health must be considered within the broader social context of that person. This is the essence of the primary health care system that we should be aspiring to, delivered by a range of health care professionals working as a team.

As highlighted in this paper the aspects of an effective primary health care system are that it is: accessible to all communities, culturally appropriate, involves community participation, is adequately funded to support the services needed to be delivered to meet the communities' health and aged care needs and to support the educational and ongoing professional development requirements of the health care professional team.

Success and sustainability of the primary health care sector will be measured in terms of engagement and capacity building of both staff and communities, evidence of ownership by communities, and ability to demonstrate that both health care professionals and the community have access to the education and information required to effect positive outcomes of health and aged care.

The ANF offers the foregoing commentary in response to the discussion paper *Towards A National Primary Health Care Strategy*, to assist the External Reference Group in its deliberations for enhancing the primary health care sector for all Australians.

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