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Response to the National Health and Hospital Reform Commission's Interim Report: 'A Healthier Future for All Australians'

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Introduction

The ANF welcomes the National Health and Hospitals (NHHRC) Interim Report and the opportunity to respond to the reform directions it outlines.

The ANF will address five specific priorities in relation to the report for the sake of brevity: workforce, aged care, primary health care, governance and funding. Other brief comments are made in relation to Indigenous health, mental health, and oral health.

Workforce

A healthier future for all Australians requires investment in the nursing workforce and reshaping of funding allocation mechanisms and service delivery models so nurses are able to work to the full scope of their practice in all settings.

Therefore the proposal to limit MBS/PBS access to nurse practitioners (NPs) in rural and remote areas or where doctors are scarce (even initially) is not supported. NPs already work in a range of settings and their effectiveness is being constrained by this limitation.

ANF opposes the use of restricted formularies for NPs and other authorised nurses and midwives. This is an inflexible mechanism that does not allow responsiveness to changing health care needs and an evolving workforce. A more flexible and effective approach would be for prescribing to occur on the basis of health professional competency and scope of practice – just as prescribing currently occurs for medical practitioners and nurse practitioners in some States.

To better meet the needs of the community, Medicare rebates and PBS subsidies should be expanded to include appropriately qualified nurses and midwives for practice in all settings inclusive of all geographical areas and socioeconomic status population groups.

While ANF supports competency based training in the VET sector, its application in the tertiary sector should be used with caution. The unique body of knowledge, tradition of critical inquiry and philosophical integrity of each of the health care disciplines must be preserved. While the identification of core competencies for all health professionals is useful in developing curricula for interdisciplinary education, education of health professionals must recognise the higher order thinking, judgement, reflection and use of intuition which characterises professional practice that cannot be acquired through task-based learning. Aggregating a set of competencies does not a professional make!

Additional resources for clinical placements and clinical training infrastructure is welcome.

ANF has concerns regarding the proposed federal agency for clinical training (National Clinical Education and Training Agency) in terms of its interface with workforce planning and potential for duplicating or replacing effective jurisdictional schemes (e.g. partnerships with education providers, centralised booking systems) to organise clinical placements.

There are risks associated with separating national workforce planning and education as current workforce shortages are due to (in part) the poor interface between workforce planning and the education sector.

In relation to the rural and remote health workforce, the increase in undergraduate and postgraduate places is welcome, but additional resources must be made available to address other predictors of successful workforce recruitment and retention in rural and remote areas, such as infrastructure, clinical education support, professional development, locum programs to facilitate leave, housing and family allowances, and other supports.

University departments of rural health care are an effective model for interdisciplinary education but all disciplines should receive equitable funding.

Aged care

The ANF holds concerns regarding the funding of aged care but does not support bonds in high care. An alternative method must be found to meet capital costs, and this must be accompanied by tighter regulation to ensure accountability and transparency in the use of funds. Improvements in accountability and transparency would allow for more effective funding allocation and planning – a process that is currently made difficult by a lack of transparency in the sector.

Removing caps on bed numbers does have the potential to create more places, however it also poses a risk that self funded places will compete with subsidised places, with a concurrent drop in the availability of the latter and the creation of a two tier “haves and have nots” type of system.

Consolidating aged care under the Commonwealth Government is supported, however far greater improvements in regulation of care quality are required in both residential and community aged care services.

Aligning community care subsidies with residential aged care is positive as it should encourage community care.

The introduction of the Respecting Patient Choices program in aged care is encouraged. Consideration should be given to the application of this program far more broadly than to the aged population to ensure that wherever possible the consumer is given choice as to their care and the setting in which it is provided.

Providing safe, high quality care for people in aged care and those in receipt of aged care services in the community cannot be achieved until there are dedicated funds for infrastructure AND care provision. ANF has serious, well founded, concerns related to the quality of care provision in aged care, where care is principally provided by unlicensed carers, and quality of care is declining. A national licensing system for assistants in nursing and care staff is vital to ensure the safety and quality of care delivered. The current wage differential of \$300 between aged care workers and nurses in other sectors must be addressed to ensure the sector can compete for qualified staff.

The ANF has concerns regarding the age limits for provision of subsidies with respect to the proposal that the limit be revised to apply to care recipients aged 85 or older. The particular circumstances of Aboriginal and Torres Strait Islander Australians should be considered in aged care planning as many Indigenous Australians require aged care services in their 50s and 60s.

Primary health care

Consolidating all primary health care services under the Commonwealth would still create a gap between primary health care and acute care.

ANF has concerns about the establishment of Comprehensive Primary Health Care Centres if they were to follow the model of GP Superclinics. The lack of recurrent funding in this model means there will be few funds available to health professionals other than a GP for whom funds will be distributed via the Medical Benefits Schedule. Unless there is funding in place to support multidisciplinary teams, this will create a situation in which professionals will compete with one another in a fee-for-service environment with no incentive to collaborate, or where doctors will be the only members of the “team”.

Nursing roles in primary health care are fragmented and largely underutilised. There are immense opportunities to enhance primary health care by supporting the integration of the current roles being undertaken in isolation by nurses and midwives (eg: maternal and child health nurses, school nurses and occupational health and safety nurses) both with one another and with other health care professionals through comprehensive primary health care hubs and e-health initiatives. What is needed is a funding system to facilitate the full scope of that expertise. Providing a blended payment system in primary health care to facilitate team based care is supported as a means to achieve this.

The proposal to establish Divisions of Primary Health Care is rejected – there is little evidence that the Divisions structure delivers any benefits to consumers, and the retention of this structure would just maintain GP dominance. While GPs play an important role in primary care (assessment, diagnosis and treatment), this is just one component of a primary health care model, with its broader remit for health promotion, intervention and illness prevention. The Divisions would be unnecessary under a regional health authority model.

Enrollment is supported however limiting it to specific groups as proposed (e.g. families and young children, people with mental illness, and disability) will still leave a lot of people with poorly coordinated care and less likely to access the benefits associated with comprehensive primary health care.

Governance

ANF supports a modified version of Option B in relation to governance i.e. a single pool of funds (including MBS and PBS), distributed to regional health authorities which should be established and managed by the States/Territories consistent with national performance targets, goals and funding allocations. Local governance is considered to be much more equitable and responsive to health needs as well as community priorities. However ANF would wish to see the roles of the states retained as deliverers of hospital services and employers of hospital staff. This measure would assist with accountability to the population given that regional authorities (unless whole of jurisdiction based) could not be politically accountable to their populations for decisions that they make.

Funding

With \$98 billion being spent annually there is a real imperative for both allocative and technical efficiency in health care funding. For this reason, the ANF queries the conclusion of the Commission in that the current mix of funding raised through taxation, private health insurance and out of pocket is optimum and should be retained.

The ANF supports the abolition of the private health insurance (PHI) rebate and urges the Commission to reconsider their conclusion. There is a great deal of evidence to suggest that: single national insurers are more cost efficient; that publicly delivered health care has lower administrative overheads than private; publicly funded systems are more equitable; the PHI rebate is “poor policy” and represents poor economics.

The Commission’s view on this is inconsistent with their expressed concerns in regard to equity and in relation to the current costs for health care borne by individuals.

Other comments

Indigenous health

There is no clear plan in the report with regard to how to close the gap in Indigenous health. ANF supports expansion of the model of Aboriginal Community Controlled Health Centres – they are an effective model for comprehensive primary health care with community governance; produce positive social *and* health outcomes; are very cost effective (but poorly funded); are culturally appropriate; and provide a valuable model not just for improving Indigenous health but for addressing inequities across many groups. The proposal regarding a requirement for curriculum for health professionals to have core Indigenous modules is supported.

A national Strategy for Indigenous Health has been developed; it now needs to be implemented. The proposal for a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap is supported.

Oral health

Separate funding of oral health will ensure it continues to be ignored as a broader health issue. Funding for oral health services should be included in a single pool and dental care provided as part of a comprehensive health primary health care service.

Mental health

A strong focus on mental health in the report is welcome and many recommendations are sound (e.g. early intervention centres). However while it is important to address mental health specifically, there is a risk associated with treating it *separately* from the rest of health, as it ignores the physical and other health needs of people with mental illness and risks fragmenting services further. As with oral health, mental health should be part of comprehensive primary health care services, using integrated teams, and in particular utilising the effective services of mental health nurses.