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

Submission to House of Representatives Standing Committee on Health Inquiry into best practice in chronic disease prevention and management in primary health care

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Executive summary

The Australian Nursing and Midwifery Federation (ANMF) welcomes the opportunity to provide advice to the Standing Committee on Health for its deliberations on best practice in chronic disease prevention and management in primary health care. As nurses and midwives are the largest component of the primary health care workforce, the issues of prevention and management of chronic diseases are well known to the ANMF nursing and midwifery membership.

The ANMF considers the Standing Committee's Terms of Reference cover a comprehensive range of issues on this matter. They should elicit robust discussion and information to assist in the Committee's considerations and subsequent recommendations for policy and funding reforms.

The commentary in our paper derives from the perspective that 'front-end' early intervention, prevention, and health promotion activities greatly diminish the need for expensive 'back-end' chronic disease management strategies. Further, we consider the main thrust of policy and funding drivers should be on the 'front-end' or mitigating activities, to rein in the growth in chronic disease in this country.

The ANMF is firmly of the view that a well-structured, well-resourced and responsive primary health care sector should be central to this country's health care system and chronic disease management. In summary, the essential elements of an effective primary health care system is that the service to clients is team based; 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; supports the education and on-going professional development requirements of the health care professional team; and is sustainable as well as flexible and responsive to the community.

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 towards prevention, early intervention, and direct easy access to appropriately qualified and skilled health care professionals, if we are to get serious about chronic disease management.

This is currently being done by nurses and midwives in a range of roles, for example, school nurses, nurses in general practice, community health nurses, maternal, child and family health nurses, and especially those working in rural and remote communities. This work needs acknowledgement, encouragement and, most importantly, increased and flexible funding.

Of importance too is for health professionals working in primary health care and chronic disease management to work collaboratively with their colleagues in local hospital networks to reduce hospital admissions and re-admissions. This collaborative effort between health professionals should ensure that health services are working towards maximum benefits for their patients and communities.

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 meeting the health care, treatment, self-management and rehabilitation needs of people, their families and communities; and their desire for humane, competent and safe care, throughout their lives.

Policy development should include a performance management and reporting framework which clearly identifies priorities and achievable key performance indicators. The focus of the key performance indicators must be on measureable health outcomes and not on a process-based or input driven approach.

Recommendations

The ANMF recommends that:

1. There be a fundamental shift in the focus of health care towards 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.
2. The Australian Government work with state, territory, and local governments, and other stakeholders, to support and promote evidence-based care, especially as it relates to Aboriginal and Torres Strait Islander health, and the general provision of quality and safety in health frameworks.
3. The Australian Government support the National Health Leadership Forum to work with state and territory governments in implementing workforce strategies to increase the Aboriginal and Torres Strait Islander health workforce.
4. The Australian Government provide recurrent and adequate funding to the Aboriginal Community Controlled Health sector at a level that allows for capacity building (people and material resources) and provision of comprehensive primary health care. This will enable the sector to prevent and manage chronic disease within Aboriginal and Torres Strait Islander communities.
5. In order to provide better access for the community to primary health care services, funding models be developed in which the funding follows the person.
6. There be subsidised funding from the Australian Government for designated nurse practitioner positions in the public sector, especially in small rural and remote communities.
7. Nurse practitioners in the public sector be given ‘request and refer’ access to the Medicare Benefits Schedule (MBS), as is the case for medical interns.

8. There be a substantial increase in the payment for MBS items for nurse practitioners in private primary health care settings, including mental health, to enable them to establish viable and sustainable practice.
9. The remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice on behalf of the GP, or under the supervision of the GP, be abolished. These item numbers are for: health assessments, chronic disease management, antenatal care, management plans, team care arrangements, spirometry, ECG, and telehealth (10986, 10987, 10997, 16400, 10983, 10984, 11506, 11700, 701-707, 715, 721, 723, 722).
10. The amount of funding for the Practice Nurse Incentive Program (PNIP) be significantly increased. Further, that this funding be uncoupled from the GP, allowing an increased number of nurses and midwives to be employed in a General Practice, working to their full scope of practice.
11. There be on-going commitment by the Australian Government to fund the Mental Health Nurse Incentive Payment (MHNIP). To ensure greater access to qualified mental health nurses by those people with chronic mental illness, the funding commitment must include discontinuation of the current arrangement for a mental health nurse to be credentialled in order to access the MHNIP.
12. The implementation of the individual electronic health record system (the opt out version) be expedited by the Australian Government, to facilitate rapid transfer of information across public and private facilities, and 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.
13. There be input from both community members and health professionals in the planning and implementation of their health care and health care services.

Introduction

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

With a membership of over 240,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

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

Together, nurses and midwives comprise over 55% of the entire health workforce. They are the most geographically dispersed health professionals in this country, and provide health care to people across their lifespan and in all socio-economic spheres. Nurses and midwives work in homes, schools, communities, general practice and medical clinics, 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 fact that nurses and midwives form the largest component of the health and aged care workforce is especially evident in primary health care settings. Primary health care is fundamental and inherent in the philosophical base of the disciplines of nursing and

midwifery. The ANMF maintains that positioning primary health care at the centre of health policy should lead to significant improvements in health for all Australians, through all stages of life.

A significant number of ANMF members are involved in the primary health care sector across the whole spectrum including but not limited to: remote area nurses, rural nurses, school nurses, maternal and child health nurses, community nurses, mental health nurses, nurses in general practice, occupational health nurses, sexual health nurses, and women's and men's health nurses. As will be outlined in this paper, these nurses and midwives are engaged in early intervention, prevention and health promotion activities to prevent or mitigate against the occurrence of chronic diseases, or in assisting clients in their management of established chronic diseases.

The ANMF, therefore, welcomes the opportunity to provide advice to the Standing Committee on Health for its deliberations on best practice in chronic disease prevention and management in primary health care. The ANMF considers the Terms of Reference cover a comprehensive range of issues on this matter and should elicit robust discussion and information to assist in the Committee's considerations and subsequent recommendations for policy and funding reforms. The commentary in our paper derives from the perspective that early intervention, prevention, and health promotion activities greatly diminish the need for expensive chronic disease management strategies. Further, we consider the main thrust of policy and funding drivers should be on the 'front-end' (mitigating) activities to rein in the growth in chronic disease in this country.

Better Prevention and Management of Chronic Disease

Australian nurses' and midwives' consensus view

In 2009, the ANMF, in conjunction with the Australian College of Nurse Practitioners, the Australian Practice Nurses Association (now Australian Primary Health Care Nurses Association), Royal College of Nursing, Australia (now Australian College of

Nursing), and the Australian College of Mental Health Nurses, developed a consensus statement on the role of the registered nurse and nurse practitioner in primary health care.[1] These organisations agreed there needed to be an enhanced model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model offering comprehensive, person centred primary health care services. The group also agreed there needed to be a broadening of 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 (including progression to chronic disease status) and injury within a primary health care milieu.

The consensus view on what primary health care should look like in Australia, if we are getting it right, is as follows:

> *The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must 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.*
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> *A variety of responsive forms of service delivery, provided by a range of providers including nurses and midwives, must be available to meet the needs of all people, including those with special needs such as intellectual disability and cultural or language barriers; and giving priority to those most in need.*

[1]Australian Nursing Federation et al. 2009. *Primary Health Care in Australia: A nursing and midwifery consensus view*. Australian Nursing Federation Federal Office. Melbourne. Available at: http://anmf.org.au/pages/professional-reports
Please note: A copy of this document is attached for the convenience of the Standing Committee.

Although agreed to in 2009, the nursing and midwifery consensus view remains relevant today. In fact, many of the nursing and midwifery groups' desired agreed changes for improvements to the primary health care arena, have not been realised. This means the community suffers and health professionals are frustrated in their efforts to improve health outcomes and reduce the impact of chronic diseases – to individuals and to society. A broader role for nurses and midwives in primary health care 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 a dual benefit of reducing demand on the acute hospital sector.

Some important points from the nursing and midwifery consensus view referred to must be brought to the attention of the Standing Committee. From their combined perspectives and extensive experience in primary health care, the parties to the consensus view provide an outline of the significant role played by registered nurses and midwives, as will be highlighted in this paper.

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; are measured and provide for positive health 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 and midwives are regulated health care professionals (statutory and self-regulation), who provide care in collaboration with other health professionals and individuals requiring care. Legislation and regulation guide nursing and midwifery

practice. Registered nurses and midwives, as qualified licensed professionals, are accountable and responsible for their own actions.

Nurses and midwives are entitled to identify the care which they are educated, competent and authorised to provide. Nurses and midwives are held accountable for their practice by the Nursing and Midwifery Board of Australia, whose role is to protect the public, as is the case for all other regulated health professions.

As regulated health professionals, registered nurses and midwives are not 'supervised' nor do they provide care 'for and on behalf of' any other health care professional. Nurses and midwives acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups.

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

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 over 1200 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, thus 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, especially chronic disease management. 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 including chronic disease management 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 and midwives. 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 and midwives - the largest combined professional health workforce in the country.

The enhanced vision of nursing and midwifery groups for the delivery of primary health care to the Australian population requires the acknowledgement at policy level of the capacity for professional nurses and midwives to make autonomous decisions. In addition, equitable funding mechanisms must be developed to facilitate the increased deployment of registered nurses, midwives, nurse practitioners and eligible midwives in primary health care services (including chronic disease management), and for the community to have access to subsidised medicines and services provided by nurse practitioners and eligible midwives.

The ANMF calls on the Standing Committee to take note of the issues raised by the nursing organisations that developed the consensus statement, in the Committee's deliberations on recommendations for better prevention and management of chronic disease in primary health care in this country.

Recommendation 1:

The ANMF recommends that there be a fundamental shift in the focus of health care towards 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.

Recommendation 2:

The ANMF recommends that the Australian Government work with state, territory, and local governments, and other stakeholders, to support and promote evidence-based care, especially as it relates to Aboriginal and Torres Strait Islander health, and the general provision of quality and safety in health frameworks.

Chronic diseases in Australia's first peoples

The commentary to follow on key points regarding chronic disease prevention and management for Aboriginal and Torres Strait Islander peoples, has been written in conjunction with our colleagues at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). The inclusion of these issues demonstrates ANMF's support for the position of CATSINaM on the role of primary health care in improving the health of Australia's first peoples.

As the principal provider of chronic disease prevention and management, primary health care is usually the first level for contact with the health care system for individuals, families, and communities, delivering health promotion, illness prevention, and community development.

The World Health Organisation's (WHO) Commission on the Social Determinants of Health, in its report on closing the gap in a generation[2], highlights the fact that there is

[2] Commission on the Social Determinants of Health (CSDH). 2008. *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/

no biological reason why there should be significant differences in life expectancy between social groups in any given country. The WHO report notes that these differences result from the conditions in which people live. To our shame this is starkly apparent in Australia, in the conditions and associated health outcomes experienced by Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander Australians suffer substantial disadvantage on all of the social determinants of health measures.

Other factors influencing engagement with, and early presentation for, health care, by Aboriginal and Torres Strait Islander people, include availability of culturally appropriate services and access to Aboriginal or Torres Strait Islander health professionals. Aboriginal and Torres Strait Islander people achieve better health outcomes when Aboriginal and Torres Strait Islander health professionals care for them. The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSIHP)[3] highlights the need for a sound primary health care system that is capable of addressing the health needs of Aboriginal and Torres Strait Islander people, and in particular, the high prevalence of chronic disease that many experience.

The NATSIHP, developed with significant input from the National Health Leadership Forum[4], identifies the opportunity for the Aboriginal Community Controlled Health (ACCH) sector to provide leadership in the development of culturally competent services across the broader health sector. Well-structured placements in the ACCH sector for nurses and midwives undertaking undergraduate or postgraduate education would increase the capacity of the health care system to provide culturally appropriate services. Such placements would also enable Aboriginal and Torres Strait Islander people to identify nursing and midwifery as a viable career opportunity.

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[3] Commonwealth of Australia 2013. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Department of Health and Ageing, Canberra ACT. Available at: http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc

[4] The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023 w*as developed in partnership between the Australian Government and Aboriginal and Torres Strait Islander people, Aboriginal and Torres Strait Islander community organisations and their peak bodies. The National Congress of Australia's First Peoples provided a critical role through the National Heath Leadership Forum in ensuring input and feedback into the development of the Health Plan.

Together with strategies to address social inequalities and the determinants of health, the NATSIHP provides the necessary platform to help realise health equality by 2031. A key priority of the plan is a robust, strong, vibrant and effective community controlled health sector. The ACCH sector is a model of comprehensive primary health care providing a more holistic suite of services than those normally found in general practice. Services include illness prevention and health promotion, clinical intervention, delivery of targeted programs (such as antenatal and immunisation), the facilitation of access to secondary and tertiary health services, and access to social and cultural services. Successful primary health care interventions are those that demonstrate genuine local Indigenous community engagement and which maximise participation up to full community control.

Examples of effective Aboriginal and Torres Strait Islander health services include:

- *Tobacco smoking cessation*: programs involve health professionals providing advice on how to quit smoking, complemented with pharmacotherapy, such as nicotine replacement, and quit smoking support groups.
- *Alcohol and other drugs*: programs involve supply reduction strategies, including price controls, restrictions on trading hours, fewer alcohol outlets, dry community declarations, substitution of Opal fuel for unleaded petrol, and culturally sensitive enforcement of existing laws. Demand reduction strategies include early intervention, provision of alternatives to drug and alcohol use, various treatment modalities, and ongoing care to reduce relapse rates. Harm reduction strategies include provision of community patrols, sobering-up shelters, and needle and syringe exchange programs.
- *Healthy lifestyle*: programs involve community participation and input from design through to implementation and evaluation. An evaluation of Indigenous-specific lifestyle programs, for example, demonstrates positive health effects remaining in people two years following program implementation. Lifestyle programs include practices such as setting clearly defined goals for weight loss and physical activity, dietary modification and weight self-management, and individual case managers or ‘lifestyle coaches’.

- *Suicide and suicidal behaviour*: community programs focus on the social, emotional, cultural and spiritual underpinnings of community wellbeing. A culturally adapted intervention comprised of motivational care planning, for example, has been effective in improving wellbeing, and decreasing alcohol and cannabis dependence among Indigenous people with chronic mental illness in three remote northern Australian communities.
- *Social and emotional wellbeing*: cultural healing programs help individuals work through their issues and exert greater control over their social and emotional wellbeing. These programs provide counselling to individuals, families and communities who would not otherwise access this service. Culturally appropriate mental health services have been successful in engaging Indigenous young people and increasing their self-esteem, their preparedness to talk to family and friends about their mental health issues, and their ability to identify signs of depression in others. Cultural adaptations of effective mainstream programs, such as the Triple P-Positive Parenting Program, the Resourceful Adolescent Program, and MindMatters, are achieving positive outcomes for Indigenous people.

The ACCH sector has assisted with tackling physical and economic barriers to health care, such as providing services locally, providing transport to health services, having flexibility in setting appointments, providing home visitation as part of a comprehensive and multifaceted engagement strategy, increasing services that do not require a co-payment and improving access to private health insurance and private health services.

The ANMF stands with CATSINaM in stressing the importance of addressing the cultural competence of service providers so they properly respect the culture of the individuals they are seeing. This means services delivered are underpinned by trust, mutual respect, and a holistic conception of health and wellbeing. Of equal importance is the employment and utilisation of the Aboriginal and Torres Strait Islander health workforce to promote, foster, and deliver culturally safe services.

Recommendation 3:

The ANMF recommends that the Australian Government support the National Health Leadership Forum to work with state and territory governments in implementing workforce strategies to increase the Aboriginal and Torres Strait Islander health workforce, particularly nurses and midwives.

Recommendation 4:

The ANMF recommends that the Australian Government provide recurrent funding needed to sustain the Aboriginal Community Controlled Health sector at a level that will allows for capacity building (people and material resources) and provision of comprehensive primary health care. This will enable the sector to prevent and manage chronic disease within Aboriginal and Torres Strait Islander communities.

Funding and governance issues

Primary health care services must be integrated with Local Hospital Networks (LHNs) to ensure partnerships with consumers, nurses, midwives, allied health professionals, medical practitioners and other providers in private and State/Territory funded public, community and primary health care, to develop joint service plans that are driven by collaboration with the community. These initiatives would ensure that the consumer receives a greater degree of service provision from a range of health professionals, which underpins primary health care.

The ANMF contends the funding of primary health care services must not be based on one organisational and administrative structure which supports private general medical primary care practice. This argument is in part due to there being other health professionals active in primary health care across all geographical areas, and, to the fact that the further rural and remote one travels, there are either fewer or no privately funded health care services. Although the health need is greater in rural and remote areas, market failure makes it next to impossible for services to be provided in a sustainable manner.

The future primary health care system, one which provides access to cost effective care and delivers the optimal health outcomes for all people in Australia, 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 ANMF has concerns about the significant issues related to Commonwealth and State/Territory funding arrangements and agreements which create a gap between primary health care and tertiary (acute) care. Reliance on the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) fee-for-service model, and lack of recurrent funding in this model, means there will be few funds available for health professionals other than a GP (to whom funds are currently distributed via the MBS). Unless there is a funding mechanism to support multidisciplinary teams to provide expertise in their clinical speciality, the situation will be created in which health 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. The freeze on indexation of all MBS fees, affecting both GPs and nurse practitioners (NPs), is also of great concern to the ANMF, as it relates to viability of service provision.

As already stated, nurses and midwives play a significant role in primary health care in this country. However, their roles in the primary health care team, including chronic disease management, are largely unrecognised and underutilised. There are immense opportunities to enhance primary health care by supporting the integration of these current nurse and midwife roles, often undertaken in isolation, (as will be outlined below), into comprehensive primary health care hubs – the new PHNs - and within e-health initiatives. This requires a funding system that facilitates the full scope of the expertise of nurses and midwives.

Providing a blended payment system (mixing fee-for-service, pre-payment and payment for performance with salaried arrangements), in primary health care, to facilitate team based care, is supported by the ANMF as a means to achieve this

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

In addition, the GP may not contribute to the chronic disease management plan, may not engage with the plan and the goals set out for the person in that plan, and at times they may not even visualise the plan prepared by the nurse. The 45-60 minute chronic disease management plan consultation the registered nurse has with the person, is billed completely to the GP who is required to sign off on the plan, but does not always add to it. This defeats the purpose of developing a team approach to a person's care when plans are not valued in the Practice as a way of managing care. Rather, these plans are seen as a means to an end to ensure 'boxes are ticked' so a person can access their free/reduced allied health visits.

There should be an expectation that chronic disease management plans are measured for outcomes to ensure they are achieving lifestyle and health improvements.

The ANMF argues for the removal of the current restriction in the Australian Government Practice Nurse Incentive (PNIP) funding for the numbers of nurses and midwives employed being tied to the number of GPs in a practice, in order to access payment for a nurse/midwife. We urge the Government to uncouple the PNIP funding of nurses and midwives in general practice from the GP (that is, deconstruct the GP:Nurse/Midwife ratio). This would enable more nurses or midwives to be employed within general practice and better meet community needs, especially in relation to chronic disease management. Further, the ANMF argues for the amount of funding for the PNIP to be significantly increased, so that, along with abolishing remaining MBS

items which restrict nurses and midwives to providing services which can be billed directly to the GP (see Recommendation 9), nurses and midwives could work to their full scope of practice - the original intent of the PNIP funding.

The ANMF strongly urges that funding models support the integration (rather than simply co-location) of a range of comprehensive services provided by a multidisciplinary team of providers such as nurse practitioners, midwives and other primary health care nurses. To best meet the needs of health consumers these providers should take their services to where people are: be that a person's home; school; community controlled primary health care centre; or place of work.

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

Population needs-based funding is the most appropriate model for ensuring that the community has access to the services it requires. With this Inquiry an opportunity exists to recommend a reduction in the transaction costs of the current fee-for-service system and de-complicate the funding arrangements for primary health care in Australia. The application of the commercial marketplace in the health context has

created some extraordinary distortions that a ‘new slate’ may correct. For example, those that have been able to pay may have been over-utilising primary health services; while those who have not been able to pay skip the primary health services and end up in a state of collapse in the acute health system, where the social and economic costs are even greater to them and the Australian society.

By 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 or midwives, 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 immigrant and refugee groups, the homeless, and sexual health workers. Effective interventions have been instituted such as screening tests, vaccinations, antibiotic therapies, antenatal care, and chronic disease management initiatives including, diabetic testing, and chronic renal and respiratory condition education.

Governments, both Commonwealth and State/Territory, are urged to strengthen the partnerships with all the stakeholders to deliver strategic outcomes. The ANMF maintains that planning for primary health care services at the local level through PHNs and the LHNs, must involve collaborative relationships with all stakeholders – all health care professionals, managers, community members, carers and volunteers, voluntary service representatives, and local councils. Further, primary health care services will only be achieved when PHNs have a more inclusive governance and operation, than was evident in the Medicare Locals. This strategy of consultation and partnership will ensure the responsibility level is close to the centre of operation of primary health care services. The resulting collaboration will increase the transparency of accountability to the community and better meet the needs of communities 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 homeless or Indigenous peoples), especially for chronic disease management.

Funding models for primary health care and chronic disease management must encompass both 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 culturally and linguistically diverse (CALD) population groups, is to provide financial and mentoring support for people from these groups to undertake education programs to become qualified health professionals.

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.

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 and communication, 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, and manage chronic conditions.

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.

Nurses, 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.

Recommendation 5:
The ANMF recommends that in order to provide better access for the community to primary health care services, funding models be developed in which the funding follows the person.

Recommendation 6:
The ANMF recommends that there be subsidised funding from the Australian Government for designated nurse practitioner positions in the public sector, especially in small rural and remote communities.

Recommendation 7:
The ANMF recommends that nurse practitioners in the public sector be given 'request and refer' access to the MBS, as is the case for medical interns.

Recommendation 8:

The ANMF recommends that there be a substantial increase in the payment for MBS items for nurse practitioners in private primary health settings, including mental health, to enable them to establish viable and sustainable practice.

Recommendation 9:

The remaining MBS item numbers allowing for the claiming of services provided by a nurse in general practice on behalf of the GP, or under the supervision of the GP, be abolished. These item numbers are for: health assessments, chronic disease management, antenatal care, management plans, team care arrangements, spirometry, ECG, and telehealth (10986,10987, 10997, 16400, 10983, 10984, 11506, 11700, 701-707, 715, 721, 723, 722).

Recommendation 10:

The ANMF recommends that the amount of funding for the Practice Nurse Incentive Program (PNIP) be significantly increased. Further, that this funding be uncoupled from the GP, allowing an increased number of nurses or midwives to be employed in a General Practice, working to their full scope of practice.

Recommendation 11:

The ANMF recommends that there be input from both community members and health professionals in the planning and implementation of their health care and health care services.

Nurses and midwives leading primary health care and chronic disease management

There are many examples across the country of models of care which could be replicated on a broader scale, to effect early intervention, prevention and safe health care in chronic disease management. These models of care provide efficiencies both by utilising the most appropriate health care professionals, and, by engaging with the community to ascertain the most appropriate solution to health and chronic condition management and outcomes.

Models supported by the ANMF are highlighted below as demonstrated exemplars of care models which utilise the available workforce in providing comprehensive primary health care in communities, including chronic disease management. 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.[5]

Occupational health nurses

There are Federal Government funded models which take multidisciplinary teams of health professionals into workplaces to provide easy access for workers to a health assessment. This is particularly pertinent in a society which is exhibiting high levels of diabetes mellitus type 2, cardiac conditions and obesity. Occupational health nurses provide for and deliver health and safety programs and services to employees, employers 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. These nurses 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 and provide health education programs, such as exercise and fitness, nutrition and weight control, stress management, smoking cessation, assistance with return to work programs of injured or ill employees, breast and testicular self-examination, management of chronic illnesses and effective use of health services.

Currently these nurses are primarily employed in large businesses. The ANMF considers the services of occupational health nurses need to be available across the whole spectrum of workplaces (private and public) to really impact the health of the

[5] Consensus paper, 2009. Ibid. p.5.

community and reduce chronic disease. In the case of small business enterprises, a group of businesses could band together to share this cost, or have the service available on a consultancy basis.

School Nurses

School nurses work in both primary and secondary education facilities. Currently, the approximately 5,200 school nurses in Australia are employed across the public and private sectors – with public:private mix and nurse:student ratios varying between jurisdictions. The ANMF argues school nurses play a vital role in primary health care and reduction of chronic disease, and thus positions should be funded within the public school sector across the country.

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, health surveillance and early identification and intervention for identified health concerns, referral, and health literacy. 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.

The following are specific examples of school nurses in one jurisdiction:

First, is a school nurse who provides a primary health care service in a suburban Melbourne primary school. With specific reference to patient safety activities this nurse has written submissions and received state government funding grants for: better hand washing equipment in the bathrooms for students and teachers; padding for schoolyard posts (basketball, netball and football), after gathering statistical data on the number of injuries caused by these hazards; provided

education and support to the whole of the school community; and, written a weekly column in the school newsletter dealing with different topics from how to clean your asthma spacer, to cough and sneeze etiquette and healthy eating, thus improving health literacy. There has been overwhelming support for this primary health care nursing role, a role that continues to evolve through consultation with the students, the teachers and the parents.

Second, it the Primary School Nursing Program (PSNP) in Victoria which provides an example of the vital role the school nurse plays in health surveillance and in the early identification of young students and families who may be in need of support, intervention and referral. The PSNP is a universal service provided to all children attending government, Catholic or independent primary school sectors and English language centre schools.

The program is designed to offer:

- *A health assessment of all prep children. This is conducted via a School Entrant Health Questionnaire (SEHQ) which the primary school provides to every family of a new prep student to complete*
- *Advice and information to parents and teachers on children's health*
- *Development of strategies to assist families to access local family support centres*
- *Referral to specialist services if required*
- *Health promotion and education*

After reviewing the SEHQ, school nurses may undertake assessments relating to vision, hearing, gait, dental hearing and speech. The school nurse will then make appropriate referral as required. In doing so, the school nurse performs a critical early identification and intervention function on matters that are integral to the student's learning capacity and the student's ability to realise his or her full potential. Additionally, school nurses support parents to provide for the needs of their children through health education and advice on matters such as sleeping, toileting, behaviour management, nutrition, weight, dental health and immunisations.

Despite this critical role, the capacity of the PSNP is constrained through existing funding, which is not adequate to meet increasing student population numbers and the increasingly complex needs of students and families.

Secondary school nurses have a key role in reducing negative health outcomes and risk taking behaviours among young people including: mental health issues, drug and alcohol abuse, unsafe sexual behaviour, smoking, eating disorders, obesity, depression, suicide, family violence, bullying, injuries, refugee health/support, homelessness ("couch surfing"). 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 life style choices. These nurses play a major role in health promotion and primary prevention.

The ANMF has a publication titled *National School Nursing Professional Practice Standards,* which emphasises the significant and comprehensive primary health care role which school nurses can, and do, undertake. This seminal document is available at: http://anmf.org.au/pages/professional-standards

School nurses are uniquely positioned to develop trusting relationships with their students. They perform holistic assessments and can identify issues which can be much more significant or serious than the issue the student may present with.

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. The ANMF stresses that this is where a major focus for policy and funding investment must in order be to break the cycle of chronic disease.

Maternal and child health nurses

Maternal and child health nurses are another group who undertake a critical primary health care role, but are grossly under-utilised in some jurisdictions. These health professionals are 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 maternal, child and family health services. There are estimated to be around 10,000 nurses working in the area of family, maternal and child health, and maternity care, with the majority of these being employed in New South Wales, Victoria and Queensland.[6]

With the growing burden of chronic disease, numbers of women having babies later in life with chronic and complex conditions is also rising. Maternal, child and family health nurses are well positioned, equipped and educated to provide comprehensive care to these women and their babies.

Again, this role is pivotal in raising a healthier population, as evidenced by the following quote from the Honorable Philip Cummins, Emeritus Professor Dorothy Scott and Mr Bill Scales in their Report to the Protecting Victoria's Vulnerable Children Inquiry, January 2012:

> *Victoria's antenatal and maternal and child health services are a cornerstone of its universal, early intervention and prevention program covering all children and are particularly important in the early care of vulnerable children. These services must be better resourced to meet the specific and demanding needs of Victoria's vulnerable children and their parents.*[7]

General practice nurses

These registered and enrolled nurses are employed by, or otherwise retained by, a General Practice. Nurses in general practice work in collaboration with general practitioners, providing a range of primary care and primary health care services,

[6]Australian Institute of Health and Welfare 2013. *Nursing and midwifery workforce 2012*. National Health Workforce Series no. 6. Cat. no. HWL 52. Canberra: AIHW.
[7] Government of Victoria. *Report of the Protecting Victoria's Vulnerable Children Inquiry*. January 2012. Available at: http://www.childprotectioninquiry.vic.gov.au

including chronic disease management, population health activities, health assessments, administering and providing advice about immunisations, identifying and providing education with regard to risk factors for chronic illness, providing health education, and monitoring the effectiveness of education and other strategies.

There are over 12,000 nurses working in private medical practices, with more than 8,500 of these nurses identifying that they are employed in general practice.[8]

Patients with chronic health issues are being targeted and signed up for their e-Health record by nurses in general practice, which is capturing those who require chronic disease management, an excellent example of patients who will benefit from an e-Health record. Many older people travel to escape the colder winter months, so the fact that they have an e-Health record means, if the person has a health issue while they are away from home, other doctors or health professionals will be able to access the e-Health record system and find out their history and medicines regime.

The nurse in general practice often actively recruit patients to register for their e-Health record when older people come in for their annual flu shots or their annual health assessment.

Rural Nursing

Rural nurses' practice varies across the country. They generally work in small communities in relative isolation, in providing health care, ranging from primary health care to emergency care through to health promotion and chronic disease prevention and management.

A small town in rural Victoria developed a model of primary health care delivery for its community that relies heavily on nurse-led services. This service is built around a small health care workforce who includes a nurse practitioner, and four nursing colleagues - together they conduct a nurse-run emergency facility, with a visiting General

[8] AIHW, 2012. Ibid.

Practitioner. The major features of this small health service 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 nurses go out into the community to visit elderly people and those with chronic disease, and the primary school children come to the centre to learn healthy cooking and exercise, as well as using the facility for concerts.

Mental Health Nurses

The ANMF members working in mental health report that clients accessing mental health care under the Mental Health Nurse Incentive Program (MHNIP) are providing a range of services that benefit clients, families and the broader community. The mental health care provision is comprehensive and assists clients to remain in the community reducing the need for hospital admission. The breadth of care includes gaining a better understanding of their illness and developing skills to recognise and self-manage responses to symptoms, educate families about mental illness, improve clients overall health and well-being and support the principles of social inclusion and integration within the community.

Importantly the MHNIP focusses on, and significantly assists clients in, their recovery from mental illness. This provides a unique opportunity for nurses to therapeutically engage with people and fully utilise their mental health nursing skills, incorporating the role of coordination of clinical care. Our members who have been employed under funding from the MHNIP report its success; and their keenness to continue working in a primary health care environment in collaboration with medical professionals and clients. It is important, therefore, that there be on-going commitment from the Australian Government to fund mental health nursing services. Failure to do so will

have a significant impact on the mental health of vulnerable people with chronic mental illnesses.

Having said that, the ANMF does not support the employment conditions which have been imposed in order to receive funding under the MHNIP. That is, in order to access the MHNIP funding, the mental health nurse must undergo a credentialling process. This is in addition to obtaining a postgraduate qualification in mental health. The ANMF contends credentialling of a nurse, who already holds an appropriate qualification that enables them to work in an area of practice, is an unnecessary and expensive extra step, which in turn impacts on availability of workforce.

The ANMF supports a funding mechanism which enables mental health nurses (who have completed a post graduate mental health nursing program of study offered by a university) to fully utilise their scope of practice so that they can deliver timely primary health care within all communities.

The ANMF contends there must be improvements in the provision of appropriate, timely and safe mental health and dementia care services in primary health care, acute care, sub-acute care and aged care settings, by competent health professionals, to reduce the occurrence of, and impact of, chronic mental health conditions.

Of immense importance is attention to social determinants of health for people experiencing mental health issues, such as: supported housing, vocational rehabilitation and post-placement employment support. Of equal importance is the integration of mental health services with meeting a person's physical health needs.

Mental health nurses are involved in early intervention services to prevent establishment of mental illness in youth and adolescents. These nurses consider too that early intervention in a person's journey is critical irrespective of age and across the mental health disease spectrum.

The development of mental health nurse outreach teams, working with the police/paramedics, is an initiative the ANMF supports to better manage people in the community requiring acute services. This includes those experiencing psychotic episodes as well as those with co-occurring conditions such as alcohol and other drug use problems existing in tandem with mental health problems – which is the rule rather than the exception.

Recommendation 11:

The ANMF recommends that there be on-going commitment by the Australian Government to fund the Mental Health Nurse Incentive Payment (MHNIP). To ensure greater access to qualified mental health nurses by those people with chronic mental illness, the funding commitment must include discontinuation of the current arrangement for a mental health nurse to be credentialled in order to access the MHNIP.

Community health nurses

Community health nursing is a combination of nursing practice, public health practice, health promotion and primary health care. These nurses and midwives work within a social model of health to provide services 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. 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 2012 AIHW survey indicates there are more than 20,000 nurses employed in community health.

Community health nurses target specific groups of clients with chronic health issues such as chronic health failure, chronic respiratory diseases, chronic renal disease and diabetes. Many clients have multiple co-morbities and it is rare for a client to have only one diagnosis.

Remote Area Nurses (RANs)

Remote area nurses (RANs) work in a range of settings across Australia, with an emphasis on remote Indigenous communities. They also work in mining, agricultural, tourism, refugee and international communities.

People living in remote areas requiring health care, face the additional challenges of limited access to services and transport. RANs caring for people in remote communities also have to cope with the distance and fewer resources than in large centres. They may work as part of a small team, even if team members are separated from one another geographically, or work independently, referring patients when further intervention is required. Often remaining available for 24 hours a day, seven days a week, the role of the RAN requires a broad range of skills and scope of practice. They provide emergency care, primary health care, education for the prevention of illness, and chronic disease management, in the context of family and community. While they can experience personal and professional isolation, these nurses describe the collaborative advanced practice and the broad set of professional skills required as unique in nursing and midwifery, and the most rewarding part of the role.

The foregoing examples highlight primary health care undertaken by nurses and midwives to improve the health status of their communities. Some additional examples from Queensland can be found through the following links:

http://www.thechronicle.com.au/news/thurston-leads-the-charge-to-tackle-flu/2621387/
http://www.healthinfonet.ecu.edu.au/about/news/3141
https://www.health.qld.gov.au/news-alerts/news/150522-swhhsflu.asp
https://www.health.qld.gov.au/darlingdowns/pdf/mr-080414thurston.pdf
https://www.health.qld.gov.au/deadly_ears/html/about.asp
https://www.health.qld.gov.au/caru/networks/diabetes.asp

All these nurses and midwives are involved in collaboration with other health professionals as they deliver care which supports the individual client to be involved in their own care. They also ensure that the recipients of their care have access to information and the education required to effect a positive and sustainable outcome for their health status.

Target groups

In the interests of improved chronic disease prevention and management in primary health care, all sectors of the community would benefit from enhanced lines of communication between the different sectors of the health and aged care system. However, while some 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 many people the whole process is incredibly daunting.

Target groups who would most benefit from active clinical care and/or service coordination between primary health care and tertiary care include people for whom English is a second language (and this includes many of our Indigenous communities), those with a low socio-economic status (especially young mothers who have no form of transport), those with severely debilitating chronic conditions/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/physical disability obstacles. People who do not have a family member support person 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.

As nurses and midwives form the largest single component of the health workforce, the ANMF considers they are well positioned to undertake the clinical care coordination role, especially for chronic disease management. This role is 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 take an 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 placed 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/midwife's role. The ANMF cautions that this aspect must be built into a primary health care nurse/midwife's job description and funded appropriately so that their role receives due acknowledgement and time allocation.

A critical component of creating a seamless passage between primary health care and tertiary sectors is improvements in information transfer. This can be achieved through the integrated electronic systems - eHealth. Ready access for all health professionals employed in primary health care and tertiary settings to email, internet, records management systems, and patient history records systems, is essential for timely and safe health information management. Health care professionals require access to information in a timely manner and consumers of care need to know that these professionals have access to this information.

The ANMF has been a strong supporter of 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! We have also advocated for the opt-out approach to the introduction of the personal health records system and welcome the proposed move to this model.

The benefits of easy access to personal health records are especially pertinent to people with chronic conditions. The record of their condition status is held in one place and accessible to all health professionals involved in care; care can be better stream-lined rather than disjointed when several health professionals are involved in their care, as is usually the case. All health professionals have access to the record and can view what others are suggesting for the care regime. This improves care by eliminating unnecessary duplication of tests and therapies, especially medicines.

Another aspect of improving access for communities to chronic disease management initiatives, especially for Aboriginal and Torres Strait Islander people and CALD 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 CALD 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 CALD populations groups.

Recommendation 12:

The ANMF recommends that the implementation of the individual electronic health record system (the opt out version) be expedited by the Australian Government, to facilitate rapid transfer of information across public and private facilities, and 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.

Nurse practitioners in primary health care and chronic disease management

As referred to previously, the ANMF contends there is potential for nurse practitioners and eligible midwives to be used more extensively across the spectrum of primary health care services, in all geographic locations. These clinical leaders practice in collaboration with other nurses and midwives, and other health professionals.

Within these multidisciplinary teams, nurse practitioners and eligible midwives can, and do, undertake important roles in providing improved access to primary health care services and chronic disease management, to individuals and communities living in rural and remote settings. This increases access for consumers to a broader range of health professionals, and to those who are particularly skilled in dealing with chronic disease management.

The ANMF is also firmly of the view that the clinical leadership of such primary health care services should be provided by persons on their merit, knowledge, skills and experience rather than professional designation. This will be more effective and sustainable than the existing system of independently operating primary health care providers with often inadequate collaboration. Funding arrangements need to change however, for this to be a viable model of practice for nurse practitioners and eligible midwives, as mentioned previously.

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

Nurse Practitioners and eligible midwives are using electronic and other contemporary forms of telecommunications such as tele-health for providing advice, support and referral purposes. Tele-health is being used for people in rural and remote centres to improve access for people to specialists in their area of chronic disease. This approach to consultations gives convenience to people with chronic conditions, provides a less painful process if the person doesn't have to travel, is better for carers, and overcomes disadvantage due to geographical location of the person. The nurse practitioner and eligible midwife can participate in the tele-health consult and assist the person as they gain access to specialist advice, treatment, monitoring and the most up to date evidence-based therapies. In addition, the nurse practitioner and eligible midwife can themselves be the specialist on the remote end of a tele-health consult with a person at their general practice or aged care facility.

Team based care

Mention has already been made of the importance of collaboration between health professionals in the delivery of primary health care and especially for the streamlining of management of complex chronic conditions. Improvements to the patient and family-centred focus of primary health care in Australia require a care co-ordination and a team based approach. For future primary health care systems 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.

Care coordination needs to be undertaken by those who understand the health care system. Nurses are, more often than not, the best placed to coordinate the care required in complex chronic conditions.

Involvement of stakeholders

Chronic disease management in primary health care must involve 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 such as the PHNs, 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 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; the current modalities don't necessarily provide for positive outcomes for people and their communities; and sustainable, replicable service delivery remains a challenge.

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

Recommendation 13:
The ANMF recommends that there be input from both community members and health professionals in the planning and implementation of their health care and health care services.

Conclusion

The nursing and midwifery workforce is currently an under-utilised resource in the primary health care arena, especially in chronic disease management. This is due either to restrictions on scope of practice or lack of recognition of role and function of nurses and midwives. The ANMF considers there needs to be a much greater utilisation of the nursing and midwifery workforce in order to ensure appropriate services for all geographical areas and population groups. Nurses 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 ANMF maintains the key to providing better access for the community to primary health care chronic disease management services is the development of funding models in which the funding follows the person/patient/client and not the provider/hospital (as in the current fee for service model).

Policy development and provision of health services for the prevention and management of chronic diseases must be shaped around the promotion of healthy living and health literacy, the prevention of disease, injury and disability; as well as meeting the health care, treatment, self-management and rehabilitation needs of people, their families and communities; and their desire for humane, safe and competent care throughout their lives.

In order to ensure the 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. The legitimacy and sustainability of major primary health care chronic disease management policy decision depends on how well it reflects 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 mitigate chronic diseases and improve management of chronic conditions.

Success and sustainability of the primary health care sector will be measured in terms of engagement and capacity building of both health professionals and communities, evidence of ownership by communities, and ability to demonstrate that both health care professionals and the community have access to the education, information and funding mechanisms required to effect positive health and aged care outcomes. The aim should be to focus on early intervention and prevention strategies leading to significantly reducing chronic conditions.