

Australian Nursing And
Midwifery Federation

Pre-Budget Submission 2020-21



Australian
Nursing &
Midwifery
Federation

INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) welcomes the opportunity to provide input to the 2020-21 Australian Government Budget.

The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight State and Territory branches, we represent the professional, industrial and political interests of over 284,000 nurses, midwives, and carers across the country.

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

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

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities. We are committed to advocating for improvements across health and aged care to the immediate action that must be taken to address the worsening and impacts of climate change.

2020 is the World Health Organization (WHO)-appointed 'Year of the Nurse and Midwife'.¹ Nurses and midwives play a fundamental role in providing health, aged care, maternity care, and mental health services across the full gamut of health care. Nurses, midwives and care workers, as the largest health care workforce are often the first and only point of care for many community members. This year, the ANMF has joined the WHO, International Council of Nurses (ICN), International Confederation of Midwives (ICM), Nursing Now and the United Nations Population Fund (UNFPA) in an effort to highlight the challenging conditions nurses and midwives often face, and advocate for increased investments in the nursing and midwifery workforce.

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



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Our submission highlights the contribution nurses, midwives, and carers currently make to Australia's health and aged care sectors and outlines how, through good, well-funded Government policy, this contribution could be dramatically increased. Adopting and implementing our submission's recommended policy reforms would result in improved cost efficiency for Governments and providers, increased patient satisfaction, better health and wellbeing outcomes, and nurses and midwives being generally happier with the work they were doing resulting in better employment recruitment and retention. The 2020-21 Federal Government Budget is a major opportunity to break down barriers that prevent nurses and midwives from working to their full potential.

Annie Butler
Federal Secretary

Lori-Anne Sharp
Assistant Federal Secretary

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NURSING AND MIDWIFERY WORKFORCE

Nursing, midwives, and carer workers represent Australia's largest workforce comprising over half of the overall healthcare workforce. In 2020 – Year of The Nurse and The Midwife, the Federal Government has a once in a generation opportunity to demonstrate its understanding of the important contributions that nurses and midwives make to our health, society and economy through effective, decisive action to give us the human and physical resources needed to get the job done. In line with the Triple Impact Report, true universal health coverage cannot be achieved or maintained without strengthening nursing and midwifery. Not only do the number of nurses, midwives, and carers need to be increased, it is also crucial to ensure their contributions to health and wellbeing are properly understood and that policy and funding enables them to work to their full potential across all settings.² The ANMF agrees that strengthening nursing and midwifery will have the triple impact of improving health, promoting gender equality and supporting economic growth.

Education and Training

1. The availability of a skilled and experienced workforce directly underpins the capacity of the health, aged care, and disability service sectors to deliver the level of care and support required now and in the future. Over the next five years, the Health Care and Social Assistance industries are projected to make the largest contributions to employment growth, with 252,600 new workers making up 15% of Australia's projected employment growth to May 2024.³ The aging population and demand via the National Disability Insurance Scheme are key factors in this growth. This projected growth includes an additional 41,000 registered nurses and midwives, 3,000 and enrolled and mothercraft nurses and around 106,400 additional personal carers and assistants including aged and disabled carers.⁴
2. While these projections suggest that Australia needs to continue investing in the education of registered nurses, enrolled nurses, midwives, and carers, they do not indicate whether the increased employment rate will actually satisfy demand.
3. The Government needs to undertake reliable workforce planning to ensure that we can continue to supply sufficient numbers of nurses, midwives, and carers to meet Australia's future demand across health, aged care, and disability service settings and across geographic regions.

² All-Party Parliamentary Group on Global Health. Triple Impact How developing nursing will improve health, promote gender equality and support economic growth [Internet]. London. October 17 2016. Available online: <http://www.appg.globalhealth.org.uk/>

³ Australian Government Department of Employment, Skills, Small and Family Business. Industry Employment Projections 2019 Report [Internet]. 22 November 2019. Available online: <http://lmp.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections>

⁴ Australian Government Department of Employment, Skills, Small and Family Business. Employment Outlook to May 2024 [Internet]. 22 November 2019. Available online: <http://lmp.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections>

4. As the recently completed national review of nursing education found, there are known disconnects between the number of graduating nursing students and the lack of jobs available for them.⁵ This review noted the wealth of evidence demonstrating that transition to practice programs reduce turnover and work stress and improve patient safety and job satisfaction.⁶ Transition to Practice Programs are important to assist nurses transitioning from education to the workforce and should be available to nurses and midwives working in any setting or context.
5. The Government needs to ensure that newly graduated nurses and midwives are provided with meaningful employment opportunities across the health and aged care sectors, including into areas of increasing demand, such as mental health, primary health care, alcohol and other drugs, and aged care. Providing adequate support for the transition of new graduates into the workforce is critical to keeping them in the workforce and therefore building an experienced nursing and midwifery workforce for the future.

6. The ANMF calls on the Government to:

- i. Partner with State and Territory Governments and nursing and midwifery organisations and peak bodies to undertake workforce assessment and planning to ensure sufficient numbers of nurses and midwives to meet Australia's future demand.
- ii. Undertake timely, accurate trend analysis of nursing and midwifery student numbers on enrolment, completion, and employment recruitment and retention rates to enable informed decision making.
- iii. Partner with health and aged care, education and training providers, health and workforce researchers and nursing and midwifery peak bodies to enable improved recruitment and retention of the nursing, midwifery, and carer workforce.
- iv. Increase employment opportunities for newly graduated and early career nurses and midwives by providing dedicated funding and resources to implement appropriate graduate Transition to Practice programs for all nurses and midwives regardless of setting, as well as in other areas of employment such as private hospitals, aged care, primary health, general practice and rural health services.
- v. Promote the recruitment and retention of newly graduated and early career nurses and midwives within the workforce by ensuring graduate transition to practice programs include adequate resourcing and clinical education to enable experienced registered nurses and midwives to provide appropriate support to early career nurses and midwives in their transition to practice.

Improving Workforce Utilisation

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

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

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

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

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

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

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

8. Australia has a skilled and highly qualified nursing and midwifery workforce which, while critical in determining national health outcomes, is largely under-utilised.¹¹ Nurses and midwives are currently denied opportunities to realise their full potential and optimally contribute to the health, aged, maternity, disability, mental health, and primary health care sectors. The ANMF argues that current funding to and structures within these sectors restrict peoples' choices for both the type of clinician and model of care used to treat and/or manage their injuries, illnesses, and conditions.
9. While the adoption of nurse- and midwife-led clinics around Australia is gradually improving, their inclusion in a broader national health, maternity, and aged care strategy is needed beyond simply where service gaps due to high demand and/or workforce shortages occur.
10. By undertaking appropriate workforce reform and expanding opportunities for proven alternative models of care, particularly in aged care, maternity care, mental health, primary care, and transition care, better and more affordable services can be offered to more people. This would involve much better use nurse- and midwife-led clinics and models of care, mental health and primary health care nurses, and nurse practitioners (NPs).

Nurse practitioners

11. An NP is a RN whose registration has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) under the Health Practitioner Regulation National Law 2009 (the National Law). The NP role is the most advanced clinical nursing role in Australia, with additional responsibilities for patient assessment, diagnosis and management, referral, medications prescribing, and the ordering and interpretation of diagnostic investigations.
12. Despite long-standing and substantial evidence demonstrating the benefits of NP-delivered care across many settings and contexts,^{12,13,14,15} NPs continue to be under-utilised and poorly supported within the Australian health and aged care sectors. As of September 2019, there were 1,904 NPs practising around Australia, an increase of only 617 in the past five years.¹⁶ This compares to the current 270,000 NPs in the United States.¹⁷ The growth rate in the number of NPs in Australia remains relatively slow; in 2014 the US had 60.22 NPs per 100,000 population while Australia only had 5 per 100,000.¹⁸

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

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

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

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

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

¹⁶ Nursing and Midwifery Board of Australia. Statistics: Nurse and Midwife Registration Data Table – September 2019 [Internet]. Available online: <https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx>

¹⁷ American Association of Nurse Practitioners. NP Fact Sheet [Internet]. August 2019. Available online: <https://www.aanp.org/about/all-about-nps/np-fact-sheet>

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

13. In Australia, while there is a growing recognition of the importance NPs, meaningful inclusion of NPs in health and aged care workforce planning has yet to occur.¹⁹ Barriers such as very limited access to the Medicare Benefits Schedule (MBS) and inadequate funding arrangements impede full utilisation of NP roles and prohibit many NPs from working to their full capacity.²⁰ A 2018 cost-benefit analysis commissioned by the Department of Health found that enabling patients to access Medicare rebates for care provided by NPs would improve access and deliver substantial savings to the health care system.²¹
14. Other important findings included cost benefit assessment evidence that;
 - The expansion of ten NP roles in aged care would cost approximately \$AUD 1.5 million per year, but conservatively result in 5,000 avoided emergency department (ED) visits each year, and annual savings of over \$AUD 5.7 million in reduced ED, hospitalisation, and ambulance costs.
 - The expansion of ten NP roles in rural and regional Australia, at \$AUD 1.5 million per year, could conservatively improve access to care for 10,000 Australians.
 - Another 10 primary care NP roles across specifically targeted locations could provide services to over 6,000 Aboriginal and Torres Strait Islander population with limited access.
15. The barriers to optimising the potential contributions of NPs results in wasted opportunities for better health and wellbeing outcomes for many, and especially the most vulnerable Australians. They also contribute to increases in health and aged care costs due to unnecessary duplication. The ANMF argues that the barriers to the employment and full utilisation of NP roles must be removed and that the number of NPs in Australia must be significantly increased.

16. The ANMF calls on the Government to:

- i. Introduce initiatives to address barriers which currently restrict the practice of nurses and midwives, a specific example would be to implement a mechanism to enable all registered nurses and NPs to complete advance care planning.
- ii. Enable nurse practitioners in the public sector access to MBS and a 'request and refer' MBS provider number to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals including allied health, when required.
- iii. Payments for MBS items for rebateable services by NPs in private primary health care settings be significantly increased, to enable them to establish viable and sustainable practice.
- iv. Fund designated salaried NP and midwife with scheduled medicine endorsement positions in the public sector, including in small rural and remote communities.
- v. Provide funding for the expansion of NP roles, nurse-led, and midwife-led clinics in health, aged care, maternity care, mental health, and primary care.
- vi. Fund designated salaried NP positions in each Primary Health Network to support residential aged care facilities in providing quality care and reduce ED presentations and hospital admissions.

¹⁹ Maier C, Batenburg R, Birch S, Zander B, Elliott R, Busse R. Health workforce planning: which countries include nurse practitioners and physician assistants and to what effect? *Health Policy*. 2018;122(10):1085-92.

²⁰ Australian Government Department of Health. Cost Benefit Analysis of Nurse Practitioner Models of Care [Internet]. A KPMG report commissioned by The Australian Government Department of Health. November 2018. Available online: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cost-ben-anal-npmoc>

²¹ Australian Government Department of Health. Cost Benefit Analysis of Nurse Practitioner Models of Care [Internet]. A KPMG report commissioned by The Australian Government Department of Health. November 2018. Available online: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cost-ben-anal-npmoc>

AGED CARE

Australia should be a world leader in aged care, but over the last 13 years, chronic understaffing has seen a 400% increase in preventable deaths of elderly Australians in aged care with hundreds dying from potentially preventable causes such as falls, choking, and suicide. Older people are our parents and grandparents, people who looked after us and loved us, but now many of them, especially those in need of high care, are left unfed, unwashed and even in soiled nappies for hours. Hard-pressed nurses and care staff do the best they can in impossible circumstances, but they are run off their feet and can't provide the care they want to, and that older people deserve. While our older people suffer and nurses and care staff struggle because there is simply not enough of them, many owners of aged care facilities profit while cutting staff.

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

'[F]ound that the aged care system fails to meet the needs of our older, often very vulnerable citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them, in too many instances, it simply neglects them.'²² (pp.5)

18. Australia's aged care system is failing and has been described by the Royal Commission, as where aged care providers and staff who succeed in the provision of safe, effective, and appropriate care are only doing so 'despite the aged care system in which they operate rather than because of it.'²³ (pp.9) The ANMF agrees with the Royal Commission that there is a need:

'[F]or a fundamental overhaul of the design, objective, regulation, and funding of aged care in Australia'.²⁴ (pp. 3)

19. The ANMF highlights that successive Governments have commissioned a range of reviews of Australia's aged care system, but that action and reform to address the underlying issues that generate the need for such reviews have been slow to occur and have often been ineffective.²⁵ Clearly, aged care services and the people that access them have not been seen as a priority for successive Governments and the ANMF argues that this must change.
20. The ANMF has argued that the instances of inadequate and substandard care that have been exposed over the last year are not isolated, exceptional, or occasional. The Royal Commission has heard that they are systemic, widespread, and even the norm. These systemic problems reflect significant flaws in the structure of the aged care system, including: inappropriate regulation of the sector; a lack of responsiveness to the changing needs of Australia's ageing population; and, a lack of transparency and accountability across the sector.

²² Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: <https://agedcare.rovalcommission.gov.au/publications/Pages/interim-report.aspx>

²³ Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: <https://agedcare.rovalcommission.gov.au/publications/Pages/interim-report.aspx> (pp. 9)

²⁴ Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: <https://agedcare.rovalcommission.gov.au/publications/Pages/interim-report.aspx> (pp. 3)

²⁵ Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: <https://agedcare.rovalcommission.gov.au/publications/Pages/interim-report.aspx> (pp. 79-81)

21. There is now considerable evidence that inadequate numbers of qualified nursing staff lead to an increased risk of negative outcomes for those in their care.
22. The ANMF highlights that chronic understaffing is a key contributor to the increasing number of instances of substandard care in Australia's aged care sector. The Royal Commission has stated that:

'The quality of care that people receive from aged care services depends very much on the quality of the paid carers and their working conditions. Workforce issues are relevant to every aspect of our inquiry.'²⁶ (pp. 232)
23. The existing consistent and irrefutable evidence that staffing is inadequate in the Australian aged care sector is born out by findings that the average rating of an Australian residential aged care facility is only two- stars for staffing (as calculated by the United States' Nursing Home Compare Rating System).²⁷ Further, on average, an Australian resident receives 36 minutes of care from a registered nurse per day - corresponding to a one-star rating. This fact is even more disturbing, considering that based on the ANMF's Staffing and Skills Mix study, a rating of less than five-stars according to this rating system would not provide safe, effective care for residents.²⁸
24. Despite the apparent and widespread problems in aged care revealed before and throughout the Royal Commission, and voiced by our members in the 2019 National Aged Care Survey,²⁹ aged care providers continue to reduce the number of nurses working in the sector.³⁰ This is despite a steadily increasing number of people entering the aged care system, many with complex needs that require care from qualified nurses and well-trained care workers.
25. The ANMF has submitted extensive evidence to the Royal Commission including work commissioned by the ANMF in 2016 which provides an evidence-based methodology taking into account the amount of time staff require for the provision of direct and indirect nursing and personal care tasks and assessments of residents.³¹
26. This baseline for staffing requirements to underpin safe, quality care in RACFs is supplemented by a cost-benefit analysis (CBA) commissioned by the ANMF and undertaken by Flinders University.³² This CBA suggests that full implementation of the recommendations of the staffing and skills mix report would be benefit cost neutral.

²⁶ Royal Commission into Aged Care Quality and Safety. 2019. Interim Report: Neglect [Internet], Commonwealth of Australia, Canberra. 2019. Available online: <https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx> (pp.232)

²⁷ Eagar K, Westera A, Snoek M, Kobel C, toggle C and Gordon R. How Australian residential aged care staffing levels compare with international and national benchmarks [Internet]. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. 2019. Available online: <https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf>

²⁸ Willis E, et al. Meeting residents' care needs: A study of the requirement for nursing and personal care staff [Internet]. Australian Nursing and Midwifery Federation. 2016. Available online: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

²⁹ Australian Nursing and Midwifery Federation (2019). ANMF National Aged Care Survey 2019 – Final Report [Internet]. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria. Available online: http://anmf.org.au/documents/reports/ANMF_Aged_Care_Survey_Report_2019.pdf

³⁰ Eagar K, Westera A, Snoek M, Kobel C, toggle C and Gordon R. How Australian residential aged care staffing levels compare with international and national benchmarks [Internet]. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. 2019. Available online: <https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf> (pp. 5-6)

³¹ Willis E, et al. Meeting residents' care needs: A study of the requirement for nursing and personal care staff [Internet]. Australian Nursing and Midwifery Federation. 2016. Available online: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

³² Burgan B, Spoehr J, Moretti C. 2017. Financial and Cost Benefit Implications of the Recommendations of the National Aged Care Staffing and Skills Mix Final Report [Internet]. Adelaide: Australian Industrial Transformation Institute, Flinders University of South Australia. Available online: http://anmf.org.au/documents/reports/ANMF_CBA_Modelling_Final_Report.pdf

27. An additional implementation plan has also been developed by the ANMF to guide Governments on how safe staffing in residential aged care can be achieved. The plan outlines the care levels that are required by people in the sector, the impact of mandating minimum staffing levels and skills mix, and describes the stages of work required from 2019-25.³³
28. While, The ANMF acknowledges that alone, mandated minimum staffing levels and skills mix may not be effective in addressing the range of systemic problems within aged care, the ANMF argues that that mandated minimum staffing levels and skills mix would be effective and amendable to inclusion alongside new technologies that enhance both care safety and quality as well as the experience and wellbeing of people within aged care.
29. The ANMF recommends that other actions must also be taken to support and sustain the delivery of safe, quality aged care. This includes but is not limited to improved education, training, and regulation of staff, an improved, transparent, and fit-for-purpose funding model, and an accessible and understandable system for ensuring that consumers are informed regarding the quality of care and staffing delivered by aged care providers. However, safe, quality care will not be achieved without mandating evidence-based minimum staffing levels and skills mix.
30. As the Australian population ages and their complex chronic health conditions increase, the need for medical care and care from other specialist health professionals, particularly NPs, will also increase. The Government must ensure that funding and regulatory structures which guarantee access to this care for older Australians are in place.
31. The ANMF supports policy initiatives that are focussed upon enabling older people to remain in their own homes for as long as possible. However, the current system and delivery of home care packages is not effectively supporting older Australians well enough and does not ensure that people are readily able to access the care they want and need when they need it.³⁴ This must be urgently addressed by the Government through better funding of home care packages and improved support for the workforce that provides this care.
32. The ANMF argues that to enhance the aged care workforce's capacity and capability to provide high quality care, support good quality of life to care recipients, and make the aged care sector a more attractive and rewarding place to work the following must occur as a matter of priority.

³³ Australian Nursing Midwifery Federation. 2019. Aged Care Ratios Make Economic Sense [Internet]. Australian Nursing and Midwifery Federation. Available online: http://anmf.org.au/documents/reports/Aged_Care_Ratios_Make_Economic_Sense.pdf

³⁴ Australian Government Productivity Commission. Report on Government Services 2020 Part F, Section 14: Aged Care Services [Internet]. Australian Government. 23 January 2020. Available online: <https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/community-services/aged-care-services>

33. The ANMF Calls on the Government to:

- i. Introduce legislative change that ensures mandatory minimum staffing levels and skills mix in residential aged care in accordance with the ANMF's evidence, i.e. a national average of 4.3 hours of care per resident per day with a skills mix of 30% RNs/20% ENs/50% carers.
- ii. Commit to full implementation of the above mandated staffing and skill mix model for residential aged care by 2025 (in accordance with the ANMF's implementation plan.³⁵
- iii. Commit to implementing legislation requiring all RACFs to publish current staffing levels and ongoing up to date information regarding staffing levels and skills mix.
- iv. Determine and fund (as required) staged staffing increases required in RACFs commencing 1 July 2020.
- v. Support the regulation of unregulated aged care workforce staff to ensure adherence to minimum education and training standards and ongoing adherence to safety and quality standards.
- vi. Fund 10-15% wage increases for all aged care workers to assist with recruitment and retention of quality workers.
- vii. Establish an appropriate education and training framework to support the development of skills and workforce numbers needed to achieve minimum staffing requirements, in collaboration with the Aged Services Industry Reference Committee.
- viii. Provide funding to educate nurses on their clinical leadership role in RACFs and home-based care and train carers in the assessment and management of the deteriorating resident. The ANMF is well placed to deliver this training.
- ix. Provide better funding support and incentives for specialist health professional in reach services to be delivered on-site at RACFs, including incentives for GPs to attend those facilities.
- x. Fund further home care packages, in particular Level 3 and 4 packages, to significantly reduce the increasing waiting list, while ensuring the allocation of available home care packages are appropriately triaged through clinical assessment by suitably qualified clinical professionals.

³⁵ Australian Nursing and Midwifery Federation. Aged Care Ratios Make Economic Sense [Internet]. Australian Nursing and Midwifery Federation. 2019. Available online: http://anmf.org.au/documents/reports/Aged_Care_Ratios_Make_Economic_Sense.pdf

PUBLIC AND PRIVATE HEALTH SECTORS

Australia's universal health care system and public and private health care sectors are some of the best in the world, but further investment and support is needed to ensure that all people achieve the best possible health and wellbeing outcomes, especially those that are most vulnerable. While many people can choose whether they want treatment in a public or a private hospital, the choice of hospital depends on a persons' condition, where they live, choice of healthcare provider, and whether someone is covered by private health insurance. Underpinning the care provided in both public and private hospitals is the workforce which is mostly made up of nurses, midwives, and carers.

34. The ANMF is committed to the provision of health as a public good with shared benefits and shared responsibilities. We consider that access to adequate health, maternity, mental health, disability care and aged care is the right of every person and a crucial element of the Australian social compact.
35. Government investment in health is a growth and infrastructure investment that will pay dividends in the development of social capital and increased productivity for generations. Proper investment is therefore essential. The Federal Government's current spending of 9.2 percent is not in line with comparable countries. In 2019, Australia ranked 11th in total health expenditure among the 36 OECD (Organisation for Economic Co-operation and Development) countries.³⁶ In the 2017–18 financial year, Australia spent an estimated \$185.4 billion on health. In real terms, this represented a 1.2 percent growth in spending from the previous year and the lowest real growth over the decade.³⁷ Over the last decade, health spending by the Federal Government has fluctuated from between 43.8 percent of the nation's total health expenditure in 2008-09 to 41 percent in 2014-15.
36. The ANMF is steadfast in its support of Medicare as Australia's publicly funded universal health insurance, as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.
37. While Australia's health system remains a world class health system and generally delivers good outcomes, too many inequalities persist. These inequalities are felt the hardest by the most vulnerable members of the population; Aboriginal and Torres Strait Islander Australians, people living in rural areas, culturally and linguistically diverse people including refugees and asylum seekers, gender and sexually diverse people, people who experience or are at risk of homelessness, and people who face socioeconomic disadvantage. The lack of a genuine 'whole of system' approach to the delivery of health care across the country coupled with a lack of system coordination, and resulting fragmentation and duplication, means too many Australians cannot access the care they want when they need it and experience poorer health and well being outcomes than other people simply because of who they are or where they live.

³⁶ Australian Institute of Health and Welfare. Australia's health expenditure: an international comparison [Internet]. Australian Government. 7 June 2019. Available online: <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-international-comparison/contents/table-of-contents>

³⁷ Australian Institute of Health and Welfare. Health expenditure Australia 2017–18 [Internet]. Australian Government. 25 September 2019. Available online: <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2017-18/contents/data-visualisation>

38. The ANMF recommends enabling increased flexibility in funding arrangements for public hospitals, the Pharmaceutical Benefits Scheme (PBS), the MBS, and aged care. Results would include the ability for regional health services to 'pool' some of these resources to meet the needs of their communities. For example, remote areas which are unable to recruit doctors could use the notional population share of the MBS to fund NP services for their communities.
39. Another key area that needs to be addressed across the sectors is the collection and management of health data, and performance reporting. It is disappointing that rates of complications by hospital, clinician, and procedure are collected by private insurance companies and State and Territory Governments, but are not readily available. Due to this lack of transparency, patients and healthcare professionals lack the information they require to make informed treatment decisions and compare performance in order to learn from hospital sites with lower complication rates.

40. The ANMF calls on the Government to:

- i. To establish an independent Health Performance Commission to be a specialist health data analytics and performance reporting body for both private and public health sectors responsible for: Mapping and co-ordinating the collection, analysis and publication of health data across the public, private and aged care sectors to enable value-based health care.
- ii. Managing end-to-end data, working from collection to publication.
- iii. Linking hospital and health data with other economic and social data as an evidence base for value-based health care and new health programs.
- iv. Developing the quality of clinical performance indicators for value-based health care;
- v. Undertaking further research to develop standardised, national nurse/midwife sensitive outcomes as important mechanisms for evaluating patient safety.
- vi. Supporting viable and sustainable improvements in healthcare efficiency that reduce unnecessary care and waste without compromising optimal consumer outcomes and working conditions for staff.
- vii. Improving access to clinical data by clinicians, boards, departmental and HHS staff.
- viii. Consulting with consumers and interest groups on the format, content, context and accessibility of publication of health care data.
- ix. Evaluating new technologies, treatments and drugs, e.g. the effective use of prostheses;
- x. Making research findings and raw data available to researchers where this has ethical approval and is in the public interest.
- xi. Liaising with other States, Territories and the Commonwealth to compare and share data, produce economies of scale and ease the ongoing disagreements over funding.
- xii. Ensuring compliance with mandatory, public reporting requirements in the public, private and aged care sectors.
- xiii. Legislated, mandatory participation of public, private and aged care sectors in the public reporting of contemporary, meaningful patient/resident safety and quality indicators.
- xiv. Nurse/midwife participation in organisational governance and quality assurance as an essential mechanism for improving clinical outcomes through public reporting.

Value-based Healthcare

41. Value-based healthcare focusses on providing the best care and outcomes possible for people who access healthcare services while most efficiently using the resources required to deliver that care. Value-based funding, also known as outcome-based funding, rewards and incentivises the achievement of better patient outcomes and wellbeing and puts people at the centre of care as opposed to a focus on simply achieving activity targets. The ANMF argues that there is a need for the Federal Government to take the lead and invest in the development of further evidence and implementation of value-based healthcare and funding models in Australia.³⁸
42. The ANMF advocates for person-centred care in all care settings, and argues that a movement toward the adoption of funding models that put people at the centre of their care is imperative. Value-based funding models involve delivering outcomes that matter to people and also considers the experiences of staff, those who require care, and their loved ones who many accompany them of be impacted by contact with the health care sector.
43. The movement towards more widespread value-based healthcare is slowly occurring in Australia,^{39,40} and the ANMF encourages the Government to examine how to better support and facilitate further uptake.
44. Key drivers for moving towards a higher-performing health care system that is focussed on delivering person-centred, value-based healthcare include; the measurement of patient and patient-reported outcomes and associated costs, the existence of up-to-date and accessible guidelines and standards for the provision of best-practice, evidence-based care, payment methods that are linked to the attainment of the outcomes of care rather than simply the delivery of care activities themselves, and effective and integrated technologies to support the accurate and efficient collection, analysis, and dissemination of data.⁴¹

45. The ANMF calls on the Government to:

- i. Commit to supporting a long-term, national, cross-sector policy and strategy for value-based healthcare.
- ii. Commit to supporting improved access to relevant and up-to-date data via the establishment of patient outcome and experience measures, clinical quality registries, improved health informatics infrastructure, international benchmarking.
- iii. Work with stakeholders to develop a national health workforce strategy that supports models of care that enable value-based approaches to healthcare.
- iv. Pursue the adoption of mixed funding formulae that appropriately utilise a blend of activity-, block-, and performance-related funding measures that incentivise the delivery of value-based healthcare.

³⁸ Woolcock K. Value Based Health Care: Setting the Scene for Australia [Internet]. Deeble Institute for Health Policy Research No. 31. Deeble Institute and the Australian Healthcare and Hospitals Association (AHHA). June 11 2019. Available online: <https://apo.org.au/sites/default/files/resource-files/2019/06/apo-nid240831-1365081.pdf>

³⁹ New South Wales Government. Value based healthcare [Internet]. December 17 2019. Available online: <https://www.health.nsw.gov.au/Value/Pages/default.aspx>

⁴⁰ Council of Australian Governments (COAG). Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform [Internet]. February 2018. Available at: <https://www.coag.gov.au/sites/default/files/agreements/heads-of-agreement-hospital-funding.pdf>

⁴¹ Australian Commission on Safety and Quality in Health Care. The State of Patient Safety and Quality in Australian Hospitals [Internet]. Australian Commission on Safety and Quality in Health Care. 2019. Available online: <https://www.safetyandquality.gov.au/sites/default/files/2019-07/the-state-of-patient-safety-and-quality-in-australian-hospitals-2019.pdf>

Public Hospitals

46. In the face of rising healthcare costs to the public,⁴² the ANMF believes that the Australian Government must take responsibility for ensuring that overall spending on public hospitals remains affordable and that policy settings contain inflation. The Government must therefore ensure that public hospital funding is directed to identified health priorities and is used efficiently to deliver safe and best practice care. Policy and regulatory controls, which control unnecessarily costly care, encourage avoidance of ineffective, care and reduce waste, should be developed and introduced.
47. The new funding agreement, which will apply from 1 July 2020, must emphasise improving efficiency and capacity while recognising the reality that significant growth in Federal Government funding is necessary to respond to growing public hospital costs. In 2016-17 the Federal Government provided 41 percent of public hospital funding, while State and Territory Governments contributed 51%.⁴³
48. The ANMF argues that in the face of Australia's aging population,⁴⁴ increasing number and proportion of admissions, health care associated infections and preventable complications,⁴⁵ lengthening public hospital waiting times,⁴⁶ and emergency department ramping.^{47,48} The new agreement must facilitate improved access to public hospital services, including elective surgery and emergency department services, and subacute care. The increasing expectations on public hospitals and staff to cope with the anticipated future productivity demands of an ageing population and greater pressure to cut waste means that substantial investment is required to supply adequate infrastructure and workforce capacity.
49. Australia lags behind many countries in terms of public reporting of healthcare safety and quality.⁴⁹ In line with the Productivity Commission's recommendations,⁵⁰ the ANMF argues that the public should have access to information regarding nurse and midwife staffing levels and patient health outcomes at all public hospital facilities. A large body of evidence supports the association between increased nurse staffing and improved quality of patient care. Public reporting of healthcare staffing patterns aims to incentivise hospitals to improve staffing by making comparison data available for consumers as well as staff and hospital administrators.⁵¹ Public reporting of nurse and midwife staffing levels should form part of the mandatory public reporting requirements for public hospitals and would enable improved consumer decision-making regarding their preferences for care. Including these factors in mandatory public reporting could also provide public hospitals with incentives to meet benchmarks for improved health outcomes overall.

⁴² Russell L Doggett J. A roadmap for tackling out-of-pocket healthcare costs [Internet]. Analysis and Policy Observatory (APO). February 2019. Available online: <https://apo.org.au/sites/default/files/resource-files/2019/02/apo-nid219221-1331226.pdf>

⁴³ Australian Institute of Health and Welfare. Hospital Resources 2017-18: Australian hospital statistics [Internet]. Australian Government. June 26 2019. Available online: <https://www.aihw.gov.au/reports/hospitals/hospital-resources-2017-18-ahs/contents/funding-and-recurrent-expenditure>

⁴⁴ Australian Institute of Health and Welfare. Older Australia at a glance [Internet]. Australian Government. September 10. Available online: <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/report-editions>

⁴⁵ Australian Institute of Health and Welfare. Admitted patient care 2017-2018 [Internet]. Australian Government. May 23 2019. Available online: <https://www.aihw.gov.au/reports/hospitals/admitted-patient-care-2017-18/contents/at-a-glance>

⁴⁶ Australian Institute of Health and Welfare. Elective surgery waiting times 2017-18 [Internet]. Australian Government. March 1 2019. Available online: <https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-17-18/contents/summary>

⁴⁷ ABC News. Third patient dies this year after ramping outside of Adelaide hospital [Internet]. Australian Broadcasting Corporation. November 18 2019. Available online: <https://www.abc.net.au/news/2019-11-18/adelaide-hospital-ramping-third-patient-dies/11712776>

⁴⁸ ABC News. Patients forced to wait in ambulances as emergency departments struggle with thousands of patients daily. Australian Broadcasting Corporation. January 22 2020. Available online: <https://www.abc.net.au/news/2020-01-22/ambulance-ramping-increasing-emergency-departments-full/11887482>

⁴⁹ Australian Commission on Safety and Quality in Health Care. The State of Patient Safety and Quality in Australian Hospitals [Internet]. Australian Commission on Safety and Quality in Health Care. 2019. Available online: <https://www.safetyandquality.gov.au/sites/default/files/2019-07/the-state-of-patient-safety-and-quality-in-australian-hospitals-2019.pdf>

⁵⁰ Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Report No. 85. Canberra: Productivity Commission, 2017.

⁵¹ De Cordova P B, Pogorselska-Mziarz M, Eckenhoff M E, McHugh M D. Pubic Reporting of Nurse Staffing in the United States. *JNR*. 2019;10(3):14-20.

50. Better use of technology is a central consideration for improving efficiency in public hospitals. Technology can better support connections between primary healthcare, and hospital care, and aged care by creating a more open infrastructure that allows multiple providers to connect to the same healthcare information. Technology improvements can improving efficiencies via more timely access to patient information for all clinical disciplines and via allowing people to readily access their own information self-management and patient empowerment is also supported.
51. Technology can also be used to improve patient outcomes remotely by supporting people to actively participate in self-management, the delivery of team-based services across the health care continuum, integrating with financial incentives to drive healthcare providers to adopt best-practice care and wellness management process for patients, and through better monitoring and reporting of trends in patient outcomes to underpin continual quality improvement.

52. The ANMF calls on the Government to:

- i. Substantially increase public hospital funding to at least 50% of all public hospital funding to address the current workforce and patient safety issues and persistent under-resourcing.
- ii. Adopt funding models that recognise growth, use incentives to encourage efficiency and a central focus on better outcomes for patients.
- iii. Implement policy and funding incentives which focus on improvements to safety and outcomes rather than penalising public hospitals for adverse patient safety events.
- iv. Introduce mandatory reporting on nurse and midwife staffing levels and patient health outcomes and reported outcomes by all public hospitals.
- v. Implement improvements to technology, including access to basic infrastructure, reliable equipment and services (e.g. internet) and providing education, training and support services for patients and providers.
- vi. Move from volume and activity-based healthcare to value-based health care system to assist health care providers to refocus on delivering health outcomes rather than meeting activity targets.

Medicare Benefits Schedule

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

Nurse practitioners

55. Not all qualified NPs are actually employed in NP roles or practising to the full scope of their role due to a range of barriers. Some of the restrictions on NP practice are:
 - the lack of positions;
 - the lack of viable employment opportunities in private practice;
 - inability to claim after-hours MBS item numbers when providing services;

- restrictions on ordering of pathology and diagnostic tests and in particular, imaging;
- the inability for people to receive certain subsidised medicines if prescribed by a NP (as distinct from a medical practitioner);
- restriction to PBS prescribing for continuing therapy only for many PBS medicines, and;
- inadequate rebates from MBS for NP services.

56. These factors severely restrict NP practice and reduce patients' access to safe and affordable care. To facilitate access to NPs a number of structures need to be put in place. Primarily, NPs in the public sector need to be given access to the MBS to allow for the delivery of comprehensive care, which includes the ability to order diagnostic investigations and refer to other health professionals including allied health, when required. That is, NPs in the public sector should be given 'request and refer' access to the MBS, just as is the case for medical interns.
57. The ANMF strongly endorses the recommendations made by the MBS Reference Groups (Nurse Practitioner and Participating Midwife) and has provided extensive comments to both groups.^{52,53} There should also be a substantial increase in the payment for MBS items for NPs in private primary health care settings, including mental health, to enable them to establish viable and sustainable practices.
58. The ability for NPs in primary health care to work to their full scope of practice is vital. NPs need to be recognised primary health care professionals, able to provide independent services under appropriately remunerated MBS item numbers.

Midwives with scheduled medicines endorsement

59. There are 562 midwives with scheduled medicines endorsement (MBS eligible midwives) in Australia.⁵⁴ The role of midwife with scheduled medicines endorsement is differentiated from other midwives by their expert practice in the provision of pregnancy, labour, birth, and postnatal care, across the continuum of midwifery care.⁵⁵
60. Similar to NPs, midwives also face barriers to practising to their full scope, again limiting their practice and reducing women's access to affordable, high quality health care. These barriers are mirrored across the two professions with midwives in private practice facing additional obstacles in obtaining professional indemnity insurance to cover the full scope of their practice.
61. Midwives in private practice have access to only one professional indemnity insurance scheme: Commonwealth-subsidised professional indemnity insurance through MIGA (Medical Insurance Group Australia) which covers antenatal and postnatal care, and birth services the midwife provides in hospital to their private clients.
62. Midwives with scheduled medicines endorsement may also encounter difficulties in establishing legislated collaborative arrangements with medical colleagues required to engage in private practice, thus forming another barrier to practising to their full scope. Collaboration between midwives and other health and medical care staff is a fundamental element of the Nursing and Midwifery Board of Australia's Midwife standards for practice

⁵² Australian Nursing and Midwifery Federation. ANMF Response to the Department of Health Primary Care Reference Groups Consultation: Medicare Benefits Schedule (MBS) Review Taskforce Report from the Nurse Practitioner Reference Group [Internet]. June 7 2019. Available online: http://anmf.org.au/documents/submissions/MBS_Review_Taskforce_Report_Nurse_Practitioner_Reference_Group.pdf

⁵³ Australian Nursing and Midwifery Federation. ANMF Response to the Department of Health Primary Care Reference Groups Consultation: Medicare Benefits Schedule (MBS) Review Taskforce Report from the Participating Midwife Reference Group [Internet]. June 7 2019. Available online: http://anmf.org.au/documents/submissions/MBS_Review_Taskforce_Report_Participating_Midwife_Reference_Group.pdf

⁵⁴ Nursing and Midwifery Board of Australia. Statistics: Nurse and Midwife Registration Data Table – September 2019 [Internet]. Nursing and Midwifery Board of Australia. September 2019. Available online: <https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx>

⁵⁵ Nursing and Midwifery Board of Australia. Endorsements and Notations: Midwife – prescribe scheduled medicines [Internet]. Nursing and Midwifery Board of Australia January 1 2017. Available online: <https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations.aspx#eligible>

(see Standard 2: *Engages in professional relationships and respectful partnerships*).⁵⁶ A 2016 study conducted in Australia with privately practicing nurse practitioners argued that mandating collaborative arrangements through legislation creates barriers to establishing private practice services which potentially inhibits consumer access to care.⁵⁷

63. As collaboration is already embedded in the way that midwives practice, mandating collaborative arrangements appears redundant and counterproductive. Midwives are regulated, qualified health professionals and as such are responsible at law for the extent and scope of their practice, undertake risk mitigation for their own practice, and are required to have professional indemnity insurance as a requirement of their registration. Health professional colleagues, including medical practitioners, do not carry responsibility for the practice of a midwife.
64. The ANMF knows that midwives want genuine collaboration, while also working autonomously within a team, so removing this requirement will not reduce their willingness to confer with their cross-disciplinary colleagues. Removing this provision will, however, contribute to a health care system that is able to capitalise on midwives' full potential, while also creating an environment that facilitates mutually beneficial, genuine cross-disciplinary consultation, collaboration, and mentorship. Making this change will result in safer, better, and better integrated maternity care.

65. The ANMF calls on the Government to:

- i. Allow NPs to be eligible, as RNs, to PNIP funding.
- ii. Provide access to 'request and refer' MBS provider numbers for NPs and midwives with scheduled medicines endorsement in the public sector, as is the case for medical interns.
- iii. Substantially increase the payment for MBS items for NPs and midwives in private practice to enable them to establish viable and sustainable practice.
- iv. Provide recurrent incentive funding for NPs and midwives in private practice to work in areas of designated District Workforce Shortage.
- v. Provide infrastructure funding for NPs and midwives to establish private practice.
- vi. Allow nurse practitioners to employ other nurses under the PNIP in the same way as GPs.
- vii. Provide NPs with MBS item numbers for after-hours services and procedural services (similar to GPs).
- viii. Allow NPs to annotate prescriptions under *Close the Gap*, in line with medical practitioners and medical specialists.
- ix. Ensure ongoing transparency throughout the MBS review process including stakeholder consultation, feedback, and final decision making.
- x. Endorse uncomplicated MBS item descriptions to support best practice clinical decision making by prescribers.
- xi. Ensure appropriate NP and midwife with scheduled medicines endorsement membership representation on Clinical Committees and Working Groups.
- xii. Support the removal of current legislated requirements that collaborative arrangements be formed in order for participating midwives to access the MBS, women and families would benefit as this will improve access to affordable, universal, and high-value care.

⁵⁶ Nursing and Midwifery Board of Australia. Midwife standards for practice [Internet]. Nursing and Midwifery Board of Australia. October 2018. Available online: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx>

⁵⁷ Currie J, Chiarella M, Buckley T. Collaborative arrangements and privately practising nurse practitioners in Australia: results from a national survey. *Aust Health Rev.* 2016;41:533-40.

National Disability Insurance Scheme (NDIS)

66. The ANMF supports the NDIS and strongly supports the Federal Government taking steps to ensure that the scheme is fully, sustainably, and appropriately funded. The ANMF is also pleased to see that the Australian Government has committed to developing an NDIS Participant Service Guarantee to support positive participant experiences with the Scheme.
67. The ANMF understands that implementation of the NDIS continues to be challenging, especially in relation to how the NDIS interfaces with non-NDIS services and can be complex and frustrating to navigate.^{58,59} For example; services provided by local governments once subsidised via Home and Community Care funding may be unsustainable with transitions to the new scheme. The ANMF is supportive of the recommendations proposed in the Tune report to improve the participant experience, including new standards and processes to support the delivery of the Participant Service Guarantee.⁶⁰
68. Providing for people affected by a disability is about ensuring that appropriate and accessible services and supports are in place to maximise the purpose, meaning, and quality of life for those living with disability. It is important to note that while having a disability is not always a health matter, disability may affect people who are impacted by other conditions, such as mental health issues.
69. Issues with NDIS coverage for people affected by mental health conditions means that some people who experience periods of disability may not be eligible for services funded through the NDIS. Likewise, those who are eligible for NDIS support may not have ready or equitable access to services, such as those living in regional and remote locations or from socially, culturally, or linguistically diverse backgrounds including Aboriginal and Torres Strait Islander people and younger people who require specialist disability accommodation.

70. The ANMF calls on the Government to:

- i. Continue to monitor and assess the rollout of the NDIS with focus on ensuring equitable coverage for those that experience disability linked to mental health conditions and those from socially, culturally, or linguistically diverse backgrounds including Aboriginal and Torres Strait Islander people and younger people requiring specialist disability accommodation.
- ii. Implement the recommendations in the Tune Review.⁶¹

⁵⁸ Parliament of Australia. Progress Report 2019: General issues around the implementation and performance of the NDIS [Internet]. Commonwealth of Australia. 29 March 2019. Available online: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/General_NDIS/Report

⁵⁹ Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: <https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report>

⁶⁰ Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: <https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report>

⁶¹ Tune D. Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee [Internet]. December 2 2019. Available online: <https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report>

Private Health Insurance

71. While the ANMF acknowledges the need for an effective private health system, we do not support the current level of public contribution via premiums. Private health insurance premiums are too high and do not provide reasonable return for all taxpayers and the wider community, in either health or economic terms. The ANMF encourages the Federal Government to introduce legislation that would ensure that private health insurance providers return a minimum of 90 per cent to customers across the industry. Enforcing a minimum payout ratio would also reduced premiums across the board, improving affordability to customers and incentives to business to operate more efficiently.
72. The Australian Government's private health insurance rebate system is uneconomic and the Australian public's perception is that it is poor value for money.⁶² The Federal Budget loses billions of dollars (projected at \$AUD 6.8 billion in 2021) and the Australian consumer is paying higher premiums despite low wages growth, reduced insurance coverage, greater out-of-pocket expenses, increasing numbers of exclusionary policies, and little impact upon the pressure on the public hospital system.
73. Private health insurance returns only 84 cents in the dollar due to financial overheads, while Medicare returns 94 cents after the costs of tax collection. This means that private health insurance may be driving up the cost of healthcare, which detrimentally impacts all Australians, but most critically, Australia's most vulnerable.

Low-value private health insurance policies

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

Financial penalties for lack of cover

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

Complex policy information

76. As indicated above, the Australian private health insurance field is marked by complex information from competing sources. Consumers need clear, accessible information from reputable sources in order to make sense of and decide upon whether private health insurance is right for their individual situations and if so which cover and what provider.
77. Practical policy reforms to enhance the affordability and value of private health insurance, and to reduce the subsidisation of private health insurance at the expense of the public health systems, need to occur.

⁶² Roy Morgan. Why have private health insurance? [Internet]. January 25 2019. Available online: <https://www.roymorgan.com/findings/7849-why-have-private-health-insurance-201901250537>

78. The ANMF calls on the Government to:

- i. Ensure that private health insurance providers pay out a minimum of 90 percent to customers across the industry.
- ii. Remove the public subsidy of private health insurance. This could be done gradually – a 10% reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals with less than a 2% reduction in private health insurance coverage.
- iii. Cut ancillary rebates, starting with removal of rebates for treatments with a poor evidence base. The savings from changes to the rebate should be redirected to the public health system.
- iv. Discontinue the availability of junk policies that are designed to solely avoid the Medicare Levy Surcharge while providing only minimal cover.
- v. Remove financial penalties for those who do not take out private health insurance regardless of their income, with a particular focus on Australians living in regional and rural Australia who receive very little benefit from holding private health insurance.
- vi. Enhance reporting requirements, analysis and data sharing to inform health outcomes, information about systems performance, adverse events and cost effectiveness;
- vii. Enhance regulation to ensure transparency from private health insurance companies in regard to policy comparisons, eligible cover, exclusions, and consumer exposure to out-of-pocket expenses particularly for low cost policies. This could be done by establishing an independent regulatory body for the sector.
- viii. Enable insurers to fund evidence-based contemporary models of care, where there is evidence of comparable or superior health outcomes and cost savings. This should include the funding of midwife- and nurse-led models of care.
- ix. Ensure that information from providers for consumers is simplified, transparent regarding cover and payout, standardised, and easily accessible.
- x. Examine initiatives to enhance access to health care for regional and rural Australians so that they can extract value from private health insurance despite geographic distance.

PREVENTIVE HEALTH/PRIMARY CARE

Preventive health is a key priority in Australia and one that is heavily reliant upon a suitably sized, educated, and supported nursing and midwifery workforce. Nurses and midwives working in preventive health provide life-saving immunisation, educate people about the need for regular health checks, identify risks for chronic disease, and offer support and care for mothers and babies. Nurses and midwives must be at the centre of preventative health strategies both as part of their normal daily work routines, and as also experts in collaborating with other health care professionals to achieve intended outcomes in policy and practice. Preventative health as well as the role of nurses and midwives in preventive health, is often overlooked by policy makers more focused on acute hospital services. This is reflected in the level of expenditure on preventative health activities in Australia.

79. Overall, Australia's health system performs very well. However, unacceptable deficiencies continue to exist. While life expectancy has increased, Australians spend a relatively higher number of years in ill-health, both in absolute terms and as a share of life expectancy. On both of these measures, Australia ranks second highest behind only Turkey and the United States, among a range of OECD and other developed countries.⁶³ The gap between overall health outcomes and indigenous health outcomes continues to be a disgrace,⁶⁴ while people in rural areas,⁶⁵ and lower socio-economic groups,⁶⁶ live shorter lives and experience more illness than those living in major cities and with higher incomes.
80. These groups have poorer access to primary care, aged care, mental health care, maternity services, dental care, allied health and specialist services and are more likely to experience problems related to obesity, alcohol use and smoking.⁶⁷ These gaps and deficiencies could, and should, be addressed through improved preventive health care.
81. Not only is prevention better than cure it makes the most economic sense. With an increasing chronic disease, cancer, and mental ill health burden, an ageing population, and many people in poorer health often from avoidable conditions, who are generally less productive,⁶⁸ it makes sense to invest where we can reap the most benefit.

⁶³ Productivity Commission. Shifting the Dial: 5 Year Productivity Commission Review [Internet]. Australian Government. 2017. Available online: <https://www.pc.gov.au/inquiries/completed/productivity-review/report>

⁶⁴ Australian Institute of Health and Welfare. Indigenous Australians [Internet]. Australian Government. Available online: <https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview>

⁶⁵ Australian Institute of Health and Welfare. Rural and Remote Health [Internet]. Australian Government. October 22 2019. Available online: <https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health>

⁶⁶ Australian Institute of Health and Welfare. Australia's health 2018 [Internet]. Australian Government. Available online: <https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents>

⁶⁷ Australian Institute of Health and Welfare. Australia's health 2018 [Internet]. Australian Government. Available online: <https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents>

⁶⁸ Productivity Commission. Mental Health Draft Report [Internet]. Australian Government. October 2019. Available online: <https://www.pc.gov.au/inquiries/current/mental-health/draft>

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

83. The ANMF calls on the Government to:

- i. Re-establish a national dedicated preventive health body.
- ii. Increase the current expenditure of 1.3 percent of total health expenditure to a target of 5 percent.
- iii. Increase incentives to encourage changes in both health provider behaviour and individual behaviour, which will lead to better health outcomes.
- iv. Establish preventive primary care systems that encourage people to enrol in wellness maintenance programs as is now occurring widely throughout the world. This approach encourages people to take responsibility for their own health with assistance from a range of health professionals such as General Practitioners and NPs without using a 'stick' or other punitive measures.
- v. Ensure that primary health networks focus on disease prevention, health promotion, equity and social determinants of health.
- vi. Investigate better and more efficient ways to fund and manage chronic conditions, e.g. blended payment models, nurse- and midwife-led models.
- vii. Establish funding arrangements which support the use of a wider range of health professionals in chronic and complex care in preventive and primary care including NPs.
- viii. Ensure that private health insurance companies are restricted from operating in primary care. Allowing private health insurance companies into this domain will increase inequity and reduce efficiency.

GENERAL PRACTICE AND PRIMARY CARE

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

84. There are currently around 14,000 nurses working in general practice.⁶⁹ While the numbers of nurses employed in the Australian general practice environment has risen rapidly over the past decade as a result of a positive policy environment and enhanced funding of nursing services, only around 63% of general practices employ at least one nurse. Workforce growth in general practice has so far occurred in a somewhat ad hoc manner as a response to various funding schemes and a gradual drive toward improved primary health care, rather than being a carefully planned workforce development. This has raised a number of challenges for the nursing profession around the role of the nurse in general practice, the nurse's scope of practice and continuing professional development opportunities. A recent study undertook simulation modelling on the general practice nursing workforce over 2012-25 and resulted in an estimated shortfall of 814 full time general practice nurses by 2025.⁷⁰
85. Prior to 2012, the Medicare Benefit Schedule (MBS) provided specific item numbers for the delivery of nursing services, such as, cervical smears, immunisations and wound care, provided 'for and on behalf of' a GP. For each occasion of nursing service, remuneration was provided to the practice from Medicare. This funding model significantly impacted on the services that were delivered by nurses in general practice.
86. On 1 February 2020 the Workforce Incentive Program (WIP) – Practice Stream began as part of the 2018/2019 *Stronger Rural Health Strategy*.⁷¹ This program provides incentive payments to accredited general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services to offset the employment of NPs, RNs, ENs, and now allied health and pharmacy staff depending upon locally assessed community needs. Only some practices will be eligible to receive the maximum incentive payment of \$AUD 125,000, which may further reduce the funding available to employ nurses in general practice.

⁶⁹ Australian Primary Health Care Nurses Association (APNA). General Practice Nursing [Internet]. 2017. Available at: <https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/general-practice-nursing>

⁷⁰ Heywood T, Laurence C. The general practice nurse workforce: Estimating future supply. *AJGP*. 2018;47(11):788-95.

⁷¹ Australian Government Department of Health. Workforce Incentive Program Questions and Answers [Internet]. Australian Government. October 31 2019. Available online: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-wip-questions-and-answers>

87. The ANMF argues for the removal of the restriction in WIP – Practice Stream funding for the numbers of nurses employed being tied to the number of GPs in a practice via the Standardised Whole Patient Equivalent (SWIPE), in order to access payment. This would enable more nurses to be employed within general practice and better meet community needs. The ANMF also argues for quarantining of funding in the WIP – Practice Stream to ensure that funding for the employment of nurses is not spent on employment of other health professionals.
88. Nurses in general practice continue to be paid considerably less than their nursing colleagues in the acute care sector. Their conditions of employment including entitlements such as leave loading, on-call rates, shift penalties, weekend allowances, annual leave, and qualifications allowance are also inferior. As has been undertaken for general practice registrars, national terms and conditions for the employment of registered and enrolled nurses in general practice should be developed as a priority.
89. The retention of some MBS item numbers has meant that the intent of the WIP to enhance the role of nurses working in general practice has not been fully achieved. Funding remains tied to specific services only. This in turn perpetuates a model whereby employers direct nurses to focus care only on those activities that can be billed through Medicare. These item numbers are for: health assessments, chronic disease management, antenatal care, and telehealth (10983, 10984, 10987, 10997, and 16400).

90. The ANMF calls on the Government to:

- i. Invest in recruitment and retention policies and activities to address the predicted shortage of general practice nurses and relatively low employment rates of nurses within Australian general practices.
- ii. Review the eligibility rules for the Workforce Incentive Program (WIP) – Practice Stream to ensure that the employment of nurses is not detrimentally impacted by funding rules.
- iii. Remove the remaining five MBS items numbers (10983, 10984, 10987, 10997, 16400) and increase WIP payment accordingly.
- iv. Fund the development of national terms and conditions for the employment of RNs and ENs in general practice. As the professional and industrial organisation representing over 284, 000 Australian nurses, midwives, and carers and collaborating with Australian Primary Health Care Nurses Association (APNA) the ANMF is best placed to conduct this activity.

MENTAL HEALTH

Nursing and midwifery play a central part in providing high quality, holistic, and accessible mental health care to community members needs. All nurses provide mental health care, with many mental health nurses also possessing additional post graduate mental health specialist qualifications. Mental health nurses benefit patients by enhancing access, continuity of care, follow-up, access to support, and adherence to mental health care plans. Midwives provide mental health care assessment, information, and support to pregnant women and new parents.

91. While around one in five Australians experiences mental ill-health across their lifetime, many do not seek support or treatment and do not receive the care they need. Far too many people suffer further preventable mental and physical suffering, breakdown of relationships, stigma, and decline in well-being, life satisfaction, and opportunities as a result.⁷²
92. Beyond the tremendous impact that mental ill-health has upon individual people, relationships, and communities, the Mental Health Productivity Commission has reported that mental ill-health and suicide conservatively costs the Australian economy between \$AUD 43 and 51 billion per year. A further cost of \$130 (AUD) is associated with diminished health and reduced life expectancy for those living with mental ill-health.
93. The current Australian health, aged, and maternity care systems are largely designed around addressing the characteristics of physical illness and injury, meaning that people who are impacted upon by mental ill-health are rarely as well served. As experts in providing holistic care, nurses and midwives are well positioned to understand and respond to the complex interrelationship between physical and mental health and to respond to the high premature mortality/morbidity rates of people being treated for mental illness.
94. Early prevention, early diagnosis, and identifying suicide risk in the treatment and management of mental ill-health is essential in minimising risk of harm and achieving positive outcomes for individuals. On many occasions nurses and midwives are best-placed to ensure that time-dependent assessments and critical interventions occur through timely recognition of problems, referral, support, and care. This is especially vital in rural, regional, and remote areas where access to specialised mental health services and general practice is limited. This is also the case for many disadvantaged and vulnerable metropolitan populations in the community (e.g. socially, culturally, and linguistically diverse and/or disadvantaged people) and people who receive aged care.
95. The ANMF contends that nurses and midwives are currently underutilised in meeting the demand for mental health care, across all geographical areas, but particularly in rural and remote settings.⁷³

⁷² Productivity Commission. Mental Health Draft Report [Internet]. Australian Government. October 2019. Available online: <https://www.pc.gov.au/inquiries/current/mental-health/draft>

⁷³ Parliament of Australia. Accessibility and quality of mental health services in rural and remote Australia [Internet]. Commonwealth of Australia. Canberra. December 4 2018. Available online: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

96. Better choice and more accessible mental health care could be provided to people through different models of care, such as mental health nurse- and midwife-led models,^{74,75} mental health NP-led models,⁷⁶ an increase in school nurse positions in the public school sector,⁷⁷ increasing nurse staffing in aged care,⁷⁸ and improving midwife mental health education and training.^{79,80}
97. Reinstating the Mental Health Nurse Incentive Payment (MHNIP) funding, quarantined within Primary Health Networks should also occur to enable reinstitution of the excellent work that had been undertaken by mental health nurses in keeping people well and living in their community.⁸¹
98. Mental health services must be appropriately tailored, accessible, to provide effective, safe, and meaningful care to the diverse Australian population. Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people (including asylum seekers, new migrants, and refugees), socially disadvantaged,⁸² and gender and sexually diverse people all face barriers to accessing safe, quality care that meets their specific needs and preferences.
99. As a workforce development strategy, the ANMF considers initiatives need to be developed and incentives need to be in place to retain the experienced mental health nursing workforce and recruit and mentor nurses and midwives new to mental health, to help grow the mental health nursing workforce. This includes transition to practice programs to equip both newly qualified and experienced RNs with the specialist skills required in mental health nursing.

⁷⁴ Harvey ST, Bennett JA, Burmeister E, Wyder M. Evaluating a nurse-led community model of service for perinatal mental health. *Collegian*. 2028;25(5):525-531.

⁷⁵ Askey-Jones S, Silber E, Shaw P, Gray R, David AS. A nurse-led mental health service for people with multiple sclerosis. *J Psychosom Res*. 2012;72(6):463-465.

⁷⁶ Wand T, D'Abrew N, Barnett C, Acret L, White K. Evaluation of a nurse practitioner-led extended hours mental health liaison nurse service based in the emergency department. *Aust Health Rev*. 2015;39:1-8.

⁷⁷ Bohnenkamp JH, Stephan SH, Bobo N. Supporting student mental health: the role of the school nurse in coordinated school mental healthcare. *Psychol Sch*. 2015;52(7):714-27.

⁷⁸ van der Wolf E, van Hooren SAH, Waterink W, Lechner L. Well-being in elderly long-term care residents with chronic mental disorder: a systematic review. *Aging & mental health*. 2017;23(3):287-96.

⁷⁹ Coates D, Foureur M. The role and competence of midwives in supporting women with mental health concerns during the perinatal period: A scoping review. *Health Soc Care Community*. 2019;27(4):e389-405.

⁸⁰ Butt J, Hauck Y, Kelly G, Dragovic M, Whittaker P, Badcock J. Midwives and perinatal mental health: Knowledge, attitudes and learning needs. *Women Birth*. 2015;28(s1):S9.

⁸¹ Happell B, Platania-Phung C. Review and analysis of the Mental Health Nurse Incentive Program. *Aust Health Rev*; 2019;43:111-119.

⁸² Royal Australian and New Zealand College of Psychiatrists (RANZCP). Minding the Gaps Cost barriers to accessing health care for people with mental illness [Internet]. RANZCP. 2015. Available online: <https://www.ranzcp.org/files/resources/reports/minding-the-gaps-cost-barriers-to-accessing-health.aspx>

100. The ANMF calls on the Government to:

- i. Invest funding into evidence-based nursing and midwifery education, training, and care-delivery programs in the health, maternity, aged care, primary health care, and education sectors.
- ii. Develop a clearly articulated policy framework that underpins health service provision, ensuring that the experience of mental health does not lead to and entrap individuals within homelessness.
- iii. Reinstate the Mental Health Nurse Incentive Payment (MHNIP) funding within Primary Health Networks.
- iv. Engage additional evaluation of the MHNIP that incorporates mental health consumers, carers, and families to enable improved person-centred care.
- v. Provide adequately funded community-based mental health nursing services that can deliver a timely, flexible, tailored response and that seeks to address the current gap, in accessing after hours mental health care.
- vi. Provide for more community based mental health in-reach nursing services to support residents within supported residential services (privately run supported housing), where they exist.
- vii. Invest in building mental health knowledge capacity in the nursing and midwifery workforce, particularly in rural and remote areas, aged care, maternity care, and primary healthcare, through resumption of quarantined scholarships for continuing professional development (CPD) and postgraduate level for registered nurses and NPs in mental health.
- viii. Provide positions for mental health NPs with funding models which broaden access for people seeking mental health care and which facilitate viable and sustainable practice operation.
- ix. Continue to raise public awareness of mental health issues to address stigma attached to those experiencing mental health issues.
- x. Ensure all people experiencing mental health conditions can access effective, quality mental health care that acknowledges their particular needs and preferences for culturally safe and appropriate care particularly for Aboriginal and Torres Strait Islander people, and those from socially, culturally and linguistically diverse and/or disadvantaged backgrounds including asylum seekers, new migrants, and refugees, and gender and sexually diverse people.

RURAL HEALTH

People who live in rural areas have a shorter life expectancy and higher levels of illness and disease risk factors than those in major cities.⁸³ In many rural and remote locations, there is only access to public health care services due to limited or no other healthcare providers. The majority of healthcare providers in rural and remote locations are nurses. Therefore, nurse-led health care is an essential component of health care delivery in these areas.

101. We estimate that of our national membership of over 284,000 nurses, midwives, and carers, in excess of 70,000 individuals live and/or work in rural and remote parts of Australia. As such, we are active on many fronts to positively influence policy in relation to the nursing and midwifery workforce and health and aged care in general. Some of our work in this space is with the National Rural Health Alliance.
102. Nurses are the most geographically well-distributed of all health professionals. The ANMF argues that better choice could be provided to people in rural and remote areas through allowing nurses and midwives to work to their full scope of practice and providing different models of care, especially via NP led models.^{84,85}
103. The ANMF supports vital, ongoing work to address the ongoing health inequities within Australia which result from disparities of opportunity and resourcing linked to distance and location. A focus on issues regarding equity of access to health care is timely, as the ANMF is particularly focussed upon addressing these issues through its involvement in the global Nursing Now campaign, culminating in 2020 – the World Health Organization-designated Year of the Nurse and the Midwife. A new Rural Health and Medical Research Network is required to address ongoing health inequities within Australia which result from disparities of opportunity and resourcing linked to the defining human spatial geography of this nation.⁸⁶ A Rural Health and Medical Research Network will provide much-needed practical infrastructure for a national research partnership focused on rural health and medical research to deliver health equity for rural Australians. Such a Network would be enabled through a partnership, collaboration and engagement model addressing critical research questions relevant to rural Australia. Key priorities of this Network would include:
 - Improving access to healthcare that meets the needs of rural communities, through technology, workforce and new models of care.
 - Developing a health driven future for sustainable rural communities by responding to the unique health challenges of place, including identifying, measuring and responding to place-based determinants such as economic, ecological, social and cultural factors; community priorities and future aspirations; health inequity and by working with adjacent sectors (eg agriculture, education, social services) to disrupt disadvantage.

⁸³ Australian Institute of Health and Welfare. Rural and Remote Health [Internet]. Australian Government. October 22 2019. Available online: <https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health>

⁸⁴ James W, Morcom M. Evolution of the nurse practitioner role at a rural health service [Internet]. 13th National Rural health Conference. 2017. Available online: http://www.ruralhealth.org.au/13nrhc/images/paper_James%2C%20Wendy_Morcom%2C%20Mandy.pdf

⁸⁵ Harvey C. Legislative hegemony and nurse practitioner practice in rural and remote Australia. Health Soc Rev. 2011;20(3):269-80.

⁸⁶ Spinifex Network. Establishing an Australian Rural Health and Medical Research Network (RHMRN)-the Spinifex Network [Internet]. Spinifex Network. Available online: <https://nswregionalhealthpartners.org.au/spinifex/>

104. Small rural maternity units can provide safe birthing services.⁸⁷ Mothers and babies are placed at risk when these services are not available locally.⁸⁸ Closing rural maternity services doesn't make economic sense for families or the health care system. It also reduces the opportunities for midwives to work in the bush. This exacerbates the workforce shortages that often lead to these closures in the first place. Timely Government investment can reverse this downward spiral. The prevalence of midwives decreases with distance from the urban centres. Support should be given to registered nurses in rural areas to complete the postgraduate midwifery education required to become dual registered, as both a registered nurse and midwife.

105. In 2017, the Australian Government awarded the tender for administration of the Health Workforce Scholarship Program to the Rural Health Workforce Agencies. Each rural workforce agency manages the Health Workforce Scholarships for the medicine, nursing, midwifery, and allied health professions for their own State or Territory. Eligibility criteria for these scholarships stipulates that health professionals employed solely by the State or Territory Government, including the State or Territory Health Department, are not eligible to apply.⁸⁹ This criterion has ruled out all but a few nurses and midwives working in rural and remote areas. The nursing and midwifery professions have not been included in the establishment or oversight of the Health Workforce Scholarship Program, as was previously the case. Consequently, there has been no information forthcoming about when scholarship applications open or data provided about uptake.

106. The ANMF calls on the Government to:

- i. Fund designated salaried positions for NPs in small rural and remote communities.
- ii. Provide scholarships for RNs in rural and remote locations to undertake postgraduate midwifery education.
- iii. Remove the restriction on rural and remote scholarship applicants by allowing access for those employed by State/Territory governments.
- iv. Require the Health Workforce Agencies to establish a national advisory committee, which includes nursing and midwifery professional organisation representatives, to provide oversight for the Health Workforce Scholarship Program.
- v. Ensure health workforce scholarship data is collected by the Health Workforce Agencies and made publicly available by the Australian Government.
- vi. Support the establishment of an Australian Rural Health and Medical Research Network.

⁸⁷ Australian College of Midwives (ACM). ACM calls for better access to maternity services for rural and remote families. ACM. 2016. Available online: <https://www.midwives.org.au/news/acm-calls-better-access-maternity-services-rural-and-remote-families>

⁸⁸ Rolfe M I et al. The distribution of maternity services across rural and remote Australia: does it reflect population need? BMC Health Serv Res. 2017;(17):163.

⁸⁹ New South Wales Rural Doctors Network. Health Workforce Scholarship Program [Internet]. 2020. Available online: <https://www.nswrpn.com.au/site/hwsp>

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

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

107. We continue to work towards our vision through our Reconciliation Action Plan, demonstrated by modelling respect for Aboriginal and Torres Strait Islander peoples; promoting understanding of their rights and leading the nursing and midwifery professions in respect and sharing knowledge with Aboriginal and Torres Strait Islander peoples.
108. The ANMF adopts the principles of reconciliation as part of our core work and models and encourages promotion of reconciliation throughout the nursing and midwifery professions.
109. The ANMF is committed to assisting the growth of the Aboriginal and Torres Strait Islander nursing, midwifery, and AIN workforce throughout Australia. To contribute to the delivery of optimal healthcare to Aboriginal and Torres Strait Islander people in every setting, it is vital that the Aboriginal and Torres Strait Islander nurse, midwife, and AIN workforce is proportional to the growing Aboriginal and Torres Strait Islander population and burden of disease, which is 2.3 times greater than non-Indigenous Australians.⁹⁰ In 2016, Aboriginal and/or Torres Strait Islander nurses and midwives accounted for only 1.03 percent of the total Australian nursing and midwifery workforce. Nationally, around 31,696 Aboriginal and Torres Strait Islander nurses and midwives are required to meet the health and wellbeing needs of the Australian population.⁹¹
110. Aboriginal and Torres Strait Islander health professionals makes a positive difference to service access, experiences, and outcomes for Aboriginal and Torres Strait Islander people. Given they have the worst health outcomes in the country it is essential that strategic and long-term efforts are made to increase the overall number and representation of Aboriginal and Torres Strait Islander nursing and midwifery students and graduates across all jurisdictions.
111. There is consistent evidence that when Aboriginal and Torres Strait Islander peoples work in the health system, Aboriginal and Torres Strait Islander people are more likely to access services and gain assistance earlier with consequent improvements in health outcomes and reductions in long term health expenditure.
112. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) is the national health professional peak body for Aboriginal and Torres Strait Islander nurses and midwives.⁹² In the early 1990s, the ANMF provided significant support for the establishment of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN). There is an historical and ongoing close relationship between the ANMF and CATSINaM.

⁹⁰ Australian Health Ministers' Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report [Internet]. AHMAC, Canberra, 2017. Available online: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/oatsih-health-performanceframework>

⁹¹ Australian Institute of Health and Welfare. National Health Workforce Data Set (NHWDS) [Internet]. 2020. Available online: <https://www.aihw.gov.au/about-our-data/our-data-collections/national-health-workforce-dataset>

⁹² Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). Available online: <https://www.catsinam.org.au/>

113. CATSINaM receives triennial grant funding from the Australian Government for their operations. Their role in providing support for Aboriginal and Torres Strait Islander nurses and midwives, nursing and midwifery stakeholders and Governments, and building the current workforce of Aboriginal and Torres Strait Islander nurses and midwives is essential.
114. The excellent work of CATSINaM in elevating the profile of their national organisation, building their Aboriginal and Torres Strait Islander nurse and midwife membership, advocating for their members, supporting recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing and midwifery and participating in research and workforce development should continue to be supported and funded.
115. Combined with effective and targeted strategies for recruitment and retention, education, training, and implementation, an appropriately sized, skilled, located, and trained Aboriginal and Torres Strait Islander nursing, midwifery, and AIN workforce would better meet the needs of Aboriginal and Torres Strait Islander people throughout Australia. Multiple stakeholders including the ANMF, CATSINaM, State and Local Governments and health services must work together to develop and implement a national strategy for the Aboriginal and Torres Strait Islander nursing and midwifery workforce. While national in scope and scale, this strategy would be flexible and account for regional and contextual differences and focus upon workforce recruitment, retention, training, and education. The National strategy would focus upon mentorships, cadetships, and Aboriginal Community Controlled Health Organisation placements for Aboriginal and Torres Strait Islander nurses and midwives, a leadership network, pathways to employment in nursing, midwifery, and AIN roles, and ongoing Government funding for CATSINaM.

116. The ANMF calls on the Government to:

- i. Provide increased ongoing funding to CATSINaM to provide leadership for nursing and midwifery organisations to work towards health equality for Aboriginal and Torres Strait Islander peoples and to continue to support and grow the Aboriginal and Torres Strait Islander nursing and midwifery workforce.
- ii. Establish a caucus of Aboriginal and Torres Strait Islander health organisations and representatives to provide regular and ongoing consultation on policies and activities that affect Aboriginal and Torres Strait Islander health and wellbeing.
- iii. Support the increase of the Aboriginal and Torres Strait Islander nursing and midwifery workforce to 5% of the total Australian nursing, midwifery, and assistant in nursing workforce across health and aged care.
- iv. Endorse and support the development and implementation of a National Aboriginal and Torres Strait Islander Nursing and Midwifery Workforce Strategy.
- v. Provide funding and support for the development, implementation, and evaluation of Birthing on Country programs in urban, regional, and remote locations.
- vi. Substantially increase funding to community-controlled, targeted, evidence-based strategies for Aboriginal and Torres Strait Islander healthcare across the life course.
- vii. Endorse and support the implementation and roll-out of nurse- and midwife-led models of care that address Aboriginal and Torres Strait Islander health concerns and challenges.
- viii. Endorse and support the development and implementation of a National Aboriginal and Torres Strait Islander Aged Care Workforce Strategy.
- ix. Fund and support the national uptake of CATSINaM's cultural safety training at all levels of healthcare service, education, and training to ensure that all healthcare professionals and educators receive best-practice cultural safety training.
- x. Support the inclusion of cultural safety training into the annual registration and continuing professional development requirements of all healthcare professionals.
- xi. Support the inclusion of measures of cultural safety with all health and aged care service providers into the National Safety and Quality Health Service Standards.
- xii. Support a revitalised nation-wide approach to addressing Aboriginal and Torres Strait Islander health and wellbeing inequalities including greater partnerships with Aboriginal and Torres Strait Islander peak bodies and leaders.
- xiii. Make a true and concerted effort to get each of the Closing the Gap targets on track including greater funding.
- xiv. Expand the Closing the Gap initiative by adding additional targets linked to incarceration, community violence, disability, aged care, and children in out of home care.

CLIMATE CHANGE AND HEALTH

As frontline health professionals, nurses and midwives experience and respond to the impact of climate change on the health of individuals and communities for whom they provide care. This has been apparent in the context of the 2019-20 bushfire and smoke event disasters, the ongoing drought, and many other natural disasters that have been caused or amplified by climate change and extreme weather patterns. Australia is now at the global nexus of climate change debate and has the opportunity to take the lead with immediate action. Nurses and midwives see the direct effects from fire, storms, drought, flood, and heatwaves; they experience the indirect effects from altered water quality, air pollution, land use change, and ecological change. The health effects include mental illness, cardiovascular and respiratory diseases, infectious disease epidemics, injuries, and poisoning.⁹³

117. Climate change presents the single largest threat to global development with the potential to undermine the past 50 years of public health gains.⁹⁴ Adverse health effects on individuals and communities will obviously impact health systems and health care delivery, with the treatment of climate change-related health conditions adding to the burden of an already stretched health care workforce.⁹⁵ A wealth of evidence demonstrates that comprehensive and practical governments responses to climate change, including significant policy and investment commitments, are urgently needed and must occur immediately before irreversible damage occurs. Governments must take immediate action to mitigate climate change and to support people and communities around the world to adapt to its impacts.⁹⁶

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

⁹³ The Lancet Commissions. Health and climate change: policy responses to protect public health. Published online June 23, 2015. Available at: www.thelancet.com

⁹⁴ International Council of Nurses (ICN). Position Statement: Nurses, climate change, and health [Internet]. Available online: https://www.icn.ch/sites/default/files/inline-files/PS_E_Nurses_climate%20change_health_0.pdf

⁹⁵ Australian Nursing & Midwifery Federation. ANMF Policy: Climate change. Reviewed and re-endorsed May 2015. Available online: <http://www.anmf.org.au>

⁹⁶ World Health Organisation (WHO). Climate Change and health: Fact Sheet [Internet]. Geneva: World Health Organisation; 2017. Available online: <http://www.who.int/mediacentre/factsheets/fs266/en/>

119. To prepare the health sector and community to deal with existing and future health effects of climate change and climate-affected disasters, we need a viable workforce and environmentally sustainable workplaces. This means commitment to, and investment in, improvements in working conditions within the health, primary care, mental health, disability and aged care sectors which already does, and will increasingly, feel the effects of health care issues resulting from climate change.
120. In many Australian health facilities, nurses and midwives are leading the way in introducing environmentally sustainable systems into their workplace practices. These initiatives should be acknowledged, applauded, replicated, and appropriately funded throughout all health and aged care facilities and care delivery settings.
121. As the largest member nation of the South Pacific region, which is the most adversely affected region globally, by the impacts of climate change, the Australian government also has a regional responsibility for leading the way in terms of actively supporting its closest neighbours to respond to and mitigate the detrimental effects of climate change.⁹⁷ Low-resourced South Pacific communities and health care systems are already struggling with the current impacts of climate change on physical and mental health as well as broader impacts upon living conditions, agriculture, and ways of life.
122. Government aid and strong, proactive leadership responding to climate change and its effects is urgently required. The time for the Australian Government to act is now, and the actions that must be taken need to be wide-ranging and considerable.

123. The ANMF calls on the Government to:

- i. Develop and implement a standalone, National Plan on Climate, Health and Well-being based on the Framework developed by the Climate and Health Alliance (CAHA)
- ii. Invest in a sustainable health workforce to prepare the health sector to deal with existing and future health effects of climate change including increased government funding for climate-resilient health systems and climate change mitigation research.
- iii. Fund programs and initiatives that support those most adversely impacted by climate change including people living in drought and disaster affected regions in Australia and neighbouring regions in the South Pacific.
- iv. Ensure a staged transition to zero emissions energy sources as a matter of urgency to avoid dangerous and irreversible impacts on the environment and the health of our communities by; developing a consistent energy policy to rapidly transition from fossil fuels to at least 50% renewable, zero-emission sources by 2030 including a clear strategy to ensure that that fossil fuels workforce is fairly and effectively supported and redeployed .
- v. Reduce greenhouse gas emissions to exceed the current 2030 Paris carbon emissions target of 26-28%.
- vi. Phase-in a fair, and effective carbon tax that does not adversely impact Australian households.
- vii. Invest greater funding in renewable energy technologies and programs to address climate change.
- viii. Develop proactive policies for mining and agriculture to reduce emissions and promote zero-emission technologies.
- ix. Develop policies that support and incentivise zero-emission public and private transport technologies.
- x. Fund States and Territories to improve the energy efficiency of hospitals and the reduction of emissions from health and pharmaceutical industry sources.
- xi. Support policies that reduce company, city, and personal environmental and climate impacts and that incentivise sustainability, zero-emissions options, and reduced environmental impact.
- i. Implement ongoing reforestation policies and practices and cease avoidable-deforestation and land clearing.

⁹⁷ Watts N, Neil Adger W, Agnolucci P, et al. Health and climate change: policy responses to protect Public health. Lancet [Internet]. 2015; 386:1861–914. Available online: [https://doi.org/10.1016/S0140-6736\(15\)60854-6](https://doi.org/10.1016/S0140-6736(15)60854-6)

TAX JUSTICE

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

124. The fair and equitable distribution of wealth throughout the Australian community is important to ensuring consistent access to all healthcare systems by all individuals. An economy that maintains such a distribution of wealth holds considerable potential to realise opportunities in the overall reduction of costs to health systems through enabled access to services, early intervention and proactive engagement.
125. The Government must ensure that fiscal policy targets an equitably distributed outcome through the appropriate selection and management of available revenue streams both at an individual level and across sectors. At around 39 percent individuals and households contribute the most significant portion of taxation revenue received by the Government,⁹⁸ and as such measures of taxation and the subsequent delivery of welfare benefits must ensure the greatest financial support of the individual falls to those who are most need it.
126. Enterprise activity in Australia contributes less than half the taxation revenue provided by the individual and household sector. Regardless of the appropriate level to which this contribution should be made, corporate tax avoidance has become a major political, economic, and social issue in Australia and further globally. Through the shifting of profit by multinational companies to locales where little to no tax is paid, local, State/Territory and Federal Governments are not realising the potential levels of tax revenue in which this system is intended to deliver. As such resulting depleted budgets has seen public services cut or placed under significant pressure despite repeated evidence of an increasing need. This is particularly the case in regard to aged care funding and other public health services in Australia.
127. The ANMF believes that instead of disadvantaging ordinary people through tight budget measures, it is time the Government took and redistributed a larger share from those involved in the billions of dollars in financial transactions. The 'Robin Hood' tax, also known as a financial transactions tax, is a 0.05% tax on institutional trades of currencies, stocks, bonds, derivatives and interest rate securities. It is widely implemented across the European Union. If governments can tax ordinary Australians on basic requirements such as housing, then they certainly can and should tax international financial transactions.
128. Significant change, positive to the requirement of all Australians is required and will not be realised without concentrated efforts and substantial political will and meaning. Collaboration and cooperation at the global scale must be pursued to provide the deserved fair and equitable distribution of wealth that we are currently failing to capture. Such actions will build sustainability in our health systems and other essential services deserved by the Australian population, whilst driving innovation and efficiencies for further gain to situate and cement Australia as a world leader in welfare and equity.

⁹⁸ The Treasury. Tax White Paper: At a glance [Internet]. Australian Government. 2017. Available online: <https://treasury.gov.au/review/tax-white-paper/at-a-glance>

129. The ANMF calls on the Government to:

- i. Reform tax concessions, i.e. limit access to growing tax concessions such as superannuation, which bring most benefit to those with high incomes.
- ii. Increase the current Newstart allowance to a level which provides the support that it is truly intended to deliver.
- iii. Require all entities receiving \$AUD 10 million in annual Government payments to file full and complete financial statements with ASIC (or ACNC for non-profits), with no exemptions.
- iv. Eliminate reduced disclosure or special purpose filing options on annual financial statements filed with ASIC for subsidiaries of multinationals with over \$AUD 500 million in annual revenues and any company with over \$AUD 10 million in annual government payments.
- v. Establish a public register of beneficial ownership of all companies and trusts.
- vi. Further reduce or eliminate ASIC fees for accessing company information over the medium-term, including financial statements, particularly in a revenue-neutral framework (such as penalties for late-filing). ASIC fees are among the highest in the world; the UK and NZ have free access.
- vii. Enhance the Government's stapled structure reforms by including transparency measures to require any listed stapled structures, in which trusts derive a majority of income from related parties, to disclose the terms of all such transactions. This measure should also apply to any company, not necessarily stapled structures, that have annual government funding of over \$AUD 10 million and that also have corporate structures with trusts receiving a majority of income from related parties.
- viii. Introduce a financial transaction tax.
- ix. Support and collaborate with global initiatives looking to prevent multinational companies shifting profits to tax haven countries.



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