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RESPONSE TO THE FINAL REPORT OF THE
NATIONAL HEALTH AND HOSPITALS
REFORM COMMISSION

A Healthier Future For All Australians

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INTRODUCTION

On 27 July 2009 the Australian Government released the final report of the National Health and Hospitals Reform Commission (NHHRC or the Commission) *A Healthier Future for All Australians: Final Report June 2009* (the Report), with 123 recommendations grouped under three primary themes of:

1. Tackling major access and equity issues that affect health outcomes for people now
2. Redesigning our health system so that it is better positioned to respond to emerging challenges, and
3. Creating an agile and self-improving health system for long-term sustainability.

The Australian Nursing Federation (ANF) strongly agrees with the Commission's view that *"the case for health reform is compelling"*.¹

The ANF supports many of the initiatives outlined in the Report and the detail in the recommendations. The move towards a more national system; the increased focus on primary health care; recognition of the imperatives and priority of improving health outcomes for Aboriginal and Torres Strait Islander peoples; greater nurturing in the early years; stronger rural health services; and the new initiatives in dental health and mental health are all welcomed. While the support for some of these recommendations is with qualification about the approach in some instances, they are all important areas for reform.

Although supporting many of the NHHRC's proposals and recognising that the overall reform initiatives are a move towards a more rational health system, the ANF is of the view that the actual proposed reforms, while obvious incremental steps, are not always sufficient or bold enough, to achieve the goals that have been articulated in the three commendable themes noted above. A number of the recommendations lack sufficient detail to enable an understanding of 'how' these reforms may be achieved. These recommendations run the risk of becoming hollow assurances if they do not provide both government and the community with the necessary clarity of direction.

The ANF is disappointed that the fee-for-service model of funding primary health care, with its innate inequity, remains as the dominant funding model. The very limited emphasis on the central importance of the social determinants of health and their relationship to other much needed infrastructure reform, is also disappointing. The recognition of the need for health reform is strong. Without a national health policy built upon the social determinants of health and a commitment to health funding designed to achieve both equity of access and of health outcomes, true reform will not be achieved. The much needed brave and comprehensive drivers for change that will make the difference for the Australian community as a whole are not sufficiently evident in this Report.

This position paper does not analyse ANF's response to each of the 123 recommendations of the Report but focuses on some of the more extensive and significant proposals where the ANF has some concerns or is of the view that there is need for further clarification or strengthening.

While acknowledging the vast coverage of subjects and issues in the Report and without diminishing the importance of other areas, the primary areas where this ANF response is concentrated are around the following important components of the Report:

1. Building better health and health care
2. Primary health care
3. Aged care
4. Health care for Aboriginal and Torres Strait Islander peoples
5. Rural and remote health services
6. Denticare Australia
7. Governance and 'Medicare Select'
8. The health workforce and education
9. Continuous learning and community engagement

For ease of analysis and clarity the format of the document follows that of the Report. In the preparation of this response, the ANF wishes to acknowledge the resources, research, information and advice of the ANF State and Territory Branches, the Australian Peak Nursing and Midwifery Forum (APNMF), the Australian Health Care Reform Alliance (AHCRA), the National Rural Health Alliance (NRHA), the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Council of Social Services (ACOSS).

TAKING RESPONSIBILITY

Individual and collective action to build good health and wellbeing - by people, families, communities, health professionals, employers, health funders and governments

RECOMMENDATIONS 1 – 15: Building good health and wellbeing into our communities and our lives

Universality

Recommendation 1 is a strong declaration of the NHHRC's commitment to the community's universal entitlement to health services, although the effect of the subtle redefinition of universalism in the Report cannot be disregarded. Many of the recommendations made by the Commission support the principle of universality of entitlement to essential care in the public system, although they do not always advance universal access, nor address some of system's current flaws in this regard. For example, the Commission has avoided addressing the issue of co-payments generally, whilst acknowledging this is a barrier to care for at least two groups – Aboriginal and Torres Strait Islander peoples and those on low income requiring dental care. The Commission propose that there be no co-payments for those groups using services. It is a significant gap in the Report that this was not extended to health services for other low income and disadvantaged groups, where evidence also shows that co-payments hinder people's access to timely and optimal care.

The issue of the subtle redefinition of universalism and the concept of a universal service obligation (especially under the proposed *Medicare Select*) needs much greater scrutiny and debate. It is noted that Recommendation 2 does foreshadow the need for *the scope of the universal entitlement and service obligation funded by public monies ... to be debated over time to ensure that it is realistic, affordable, fair, and will deliver the best health outcomes, while reflecting the values and priorities of the community.* The debate on how to fund health services and what to fund is long overdue. The mechanism to ensure meaningful community consultation and input on this issue will be crucial, especially given evident cynicism by politicians from both major parties concerning representative versus participative models of democratic debate. The Report makes some very important points about 'strengthening consumer engagement and voice'. Disappointingly, the recommendations do not have any real guidance in this area, for example Recommendation 93. The ANF would have liked to have seen this requirement embedded in many of the recommendations concerning policy, service delivery, governance and funding reform.

The ANF is also critical of the failure of the Report to address the current government approach to the funding and support of the private health sector and the private health insurance system. This is significant as the inequities that emerge by creating classes of service access have the potential to undermine the principle of universality. It means that we retain a system where there is universal entitlement but universal access still depends on a person's financial capacity and their geographic location in relation to required services.

National goals, information, data and reporting

Overall, the ANF supports the recommendations in relation to the development of longer term national goals based around health promotion and prevention. This goes hand in hand with the recommendations for the development and collection of better qualitative and quantitative data and reporting in relation to community opinion, health status, health service use and health outcomes. This support is with the caveat that these are developed with strong citizen and community involvement; have input from the full range of health providers; are informative and useful for ALL stakeholders such as local communities, health services and government; and are not censorable when they reveal poor performance or gaps in access and equity.

Improving health literacy and health care records

The ANF supports the recommendations relating to improving health literacy; access to evidence based, consumer-friendly information; the ownership and control of their own personal health care records by each person; and advanced care planning as important steps in addressing the current disparity in the power relationships between health providers and health consumers. However, the concept of choice (informed choice in particular) is problematic in health care due to many complex and interconnecting factors and barriers such as access to care as well as the imbalance in power relationships between recipients of care and providers of care; and these are not sufficiently examined in the Report.

The recent statement by nurses and midwives - *Primary Health Care in Australia: A nursing and midwifery consensus view* provides strong support for Recommendation 13 in relation to the personal electronic health care record:

*"A lifetime health care record for each person in the Australian community is an essential requirement for enabling them and those in primary health care and other health care teams to support them to maintain their health and manage any health care, treatment, rehabilitation and palliation required during their lifetime. This record remains in the control of the person who is its subject (or their representative) and its contents safeguarded according to the National Privacy Principles and cultural standards and requirements."*²

It is very important to build community confidence in such a health care record and its appropriate use. Some communities such as a number of Aboriginal and Torres Strait Islander communities have had very confronting experiences with the inappropriate accessing of personal health care and other information by unauthorised persons and agencies.

The Recommendation is, however, based upon the assumption that each person who owns and controls the record, and any health care provider they may connect with, has access to the electronic systems required to open, utilise and contribute to the content of such a record. Currently in Australia, that assumption requires an immense leap of faith. The present Australian Government National Broad Band strategy should be an important enabler for this Recommendation being realised, but other capacity issues will have to be managed. The retrospective compilation of such health care records will be a challenge for the current generations but is not insurmountable. Nurses and midwives have an important contribution to make working with health consumers and supporting them to ensure their health care record is developed and managed in a way that functions legally and ethically in the consumer's best interests. This is a key initiative and will significantly contribute to shifting the inherent power imbalance from health service provider to health consumers, while also diminishing the potential for fragmentation of care due to incomplete health information being available at important times of social and clinical decision making.

The social determinants of health

The cursory treatment of probably one of the most important aspects of a National Health Care Policy in Recommendation 15, the social determinants of health, is regrettable. On launching the final report of the Commission of the Social Determinants of Health, a Commission established by the World Health Organisation (WHO) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*,³ Dr Margaret Chan, the Director General of WHO said:

*"Health inequity really is a matter of life and death. The Commission's main finding is straightforward. The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one... This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health... But, let me emphasize, it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."*⁴

While Recommendation 15 acknowledges the importance of these social determinants of health, there is relatively little substance in this Recommendation or other recommendations in the Report to suggest how the health system may address or drive change in relation to these factors. As well as health care generally, other critical areas for action include: early years' life support and care (an area that is well dealt with in *Recommendations 22 – 26 Nurturing a healthy start*); ecosystem sustainability; education; employment; food and water security; housing; income; social inclusion; and social welfare. In relation to the eight latter factors, there is little guidance on how the health system can work more cogently and cooperatively with responsible government and other agencies to manage and improve the critical relationships between each of these. Nurses and midwives have identified the imperative of actively addressing these social determinants of health as being an essential element in their vision for primary health care in Australia.²

CONNECTING CARE

Comprehensive care for people over their lifetime

RECOMMENDATIONS 16 – 21: Creating strong primary health care services for everyone

Commonwealth taking on responsibility for all primary health care

The increased focus on primary health care is welcomed by the ANF. The ANF has been a strong proponent of the development of a consensus view of primary health care among nurses and midwives in Australia and has, as a consequence, developed the firm view that primary health care should become the centrepiece of national health policy,² a view that is clearly articulated in the Report.

The ANF strongly supports the move towards a national health policy and well integrated health system. Hence, the proposition that the policy framework, governance and funding of all health services requires national leadership and local flexibility is seen as an imperative.

Recommendation 16, advocating that the Commonwealth take on responsibility for all primary health care services suggests a considerable improvement on the current fractured and inequitable system, and is therefore supported in principle. The strategies and detail of how this will occur is not fully outlined in the Report. The ANF's support is therefore qualified at this time, conditional upon the cogency of the detailed strategies developed to achieve the objective of comprehensive care for people over their lifetime.

Comprehensive primary health care services

The ANF strongly supports the notion of establishing comprehensive primary health care **services**. The emphasis in Recommendation 17 on Comprehensive Primary Health Care **Centres** tends to perpetuate the rather paternalist notion of provider centred care – *build it and they shall come!* The ANF acknowledges the importance of an appropriate environment for health care and treatment to be provided, and the merit in having co-located and integrated services for a ‘one stop shop’ in some instances. An over-emphasis on the premises for service delivery is counterintuitive to the philosophy of primary health care.

Primary health care or primary care?

The ANF is of the view that the discussion in the Report reflects a continuing adherence to the ‘primary care’ model of care that has prevailed in Australia through the traditional form of general medical practice care over the last century. ‘Primary health care’ is not just medical care. Primary health care is a broader model of person-centred, multidisciplinary care that has been adopted internationally under the auspices of the World Health Organisation (WHO) as ‘primary health care’.^{5,6} Models where the focus is the centre or a place of centralised delivery (and hence the providers) and not the service, ignore the primary tenets of primary health care articulated in the Australian nurses’ and midwives’ consensus view:

“Primary health care is a holistic approach incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of essential, integrated, quality care based upon practical, scientifically sound and socially acceptable methods and technology. It is made accessible to all people, families and communities as close as possible to where they live and through their full participation, in the spirit of self-reliance and self-determination; and at a cost that the Australian community can afford.

Primary health care forms an integral part both of Australia's health system, of which it is the nucleus, and of the overall social and economic development of the community.

The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must meet the health care, treatment, self management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care across the period of their lives.

A variety of responsive forms of service delivery, provided by a range of providers, including nurses and midwives must be available to meet the needs of all people, including those with special needs such as intellectual disability and cultural or language barriers; and giving priority to those most in need.”²

Funding primary health care services

The funding models proposed for primary health care are a great source of disappointment and frustration to the ANF. For example, the retention of fee-for-services in such comprehensive primary health care services for any GPs (and perhaps for other health professionals working in primary health care services, although how they will be funded is not clear) is likely to maintain at least some of the inequity in the current system. Having different funding models attached to different health providers in one service merely complicates what is already a complex system and confuses the community. The ANF certainly does not support the delegated funding model proposed in Recommendation 99, for two reasons: it presumes that the medical practitioner will be the gatekeeper for care, treatment and referrals; and it removes the accountability from the person who is the direct provider of the care or service.

The ANF strongly urges that funding models support the integration (rather than simply co-location) of a range of comprehensive services provided by a multidisciplinary team of providers such as nurse practitioners, midwives and other primary health care nurses. To best meet the needs of health consumers these providers should take their services to where people are: be that a person's home; school; community controlled primary health care centre; or place of work. Population needs-based funding is the most appropriate model for ensuring that the community has access to the services it requires. In this reform environment, an opportunity exists to reduce the transaction costs of the current fee-for-service system and de-complicate the funding arrangements for primary health care in Australia. The application of the commercial marketplace in the health context has created some extraordinary distortions that a 'new slate' may correct. For example, those that have been able to pay may have been over utilising primary health services; while those who have not been able to pay skip the primary health services and end up in collapse in the acute health system where the social and economic costs are even greater to them and the Australian society.

Clinical leadership

This proposal also embeds the notion that the medical practitioner is the clinical team leader – a presumption that must be debunked! Extraordinary primary health care is provided by Aboriginal health workers, nurses, midwives, nurse practitioners, psychologists and other health professionals in caravan parks, schools, correctional facilities, boarding houses, brothels, aged care facilities, community mental health services, drug and alcohol centres, people's homes, workplaces, on the streets and many other sites. Medical and other clinical advice may be sought, obtained and consumers referred to, but the team should be led by the most appropriate health professional based on merit, not professional grouping. The health professionals listed above are regulated, accountable and responsible for the care they provide in their own right.

The idea of utilising nurse practitioners in the primary health care workforce should not just be rolled out where doctors are scarce, as suggested by the Commission. The ANF is strongly of the view that there is great potential for Nurse Practitioners to be used across the spectrum of primary health care services as well as in acute care, sub-acute care and aged care; and in all geographic locations.

As the Report proposes, this new comprehensive model for primary health care should increase access for consumers to a broader range of health professionals. This relies on an integrated, collaborative team model not simply co-location of independent practitioners. The ANF is also firmly of the view that the clinical leadership of such primary health care services should be provided by persons on their merit, knowledge, skills and experience rather than professional designation. This will certainly be more effective and sustainable than the existing system of independently operating primary health care providers with often inadequate collaboration.

There is also the potential for stronger consumer participation in policy development, management and governance more generally, of larger, comprehensive primary health care services, than has been possible in multiple, separate small private practices.

Enrolment in a single primary health care service

Recommendation 18 proposes that *young families, Aboriginal and Torres Strait Islander peoples, and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, coordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal 'health care home'.*

The ANF supports this recommendation with some qualifications. While it is acknowledged that it is not a proposal with universal application, it is reasonable to focus on the needs of people who would most benefit from more comprehensive and integrated health services. It should make a broader range of primary health care services more accessible by enabling access to care provided by nurse practitioners, midwives and other health practitioners providing care to meet individual needs, focusing on prevention and early intervention; and move services away from the absurd and universally frustrating model of 'six minute medicine'.

The ANF notes the comments of the National Aboriginal Community Controlled Health Organisation (NACCHO) in relation to this recommendation and is of the view that its concerns be taken into account when developing an appropriate funding model for comprehensive primary health care service delivery. It is NACCHO's view that it is premature to suggest that voluntary enrolment of Aboriginal patients with primary health care services of their choice will make any difference to health service access to this population.

Moreover, without understanding what performance outcomes might be linked with grants to services, it is possible that this approach might encourage more fee-for service distortions of health care delivery. Currently, for example, MBS claims are one of the measured outcomes. Blended payments have been around for a while and have not been found to benefit Aboriginal community controlled health services. Advice from NACCHO also indicates that people are mobile for a range of reasons and tying funding to a person's usual care provider can make access to appropriate services difficult and ultimately inequitable. For Aboriginal and Torres Strait Islander peoples, NACCHO argues that the systems have to be developed very carefully and with direct partnership with the elected NACCHO leadership.

Similarly, the ANF would strongly recommend the participation of the other key groups such as young families and people with chronic and complex care conditions in the development of this policy. The high risk of such a seemingly important and beneficial recommendation is that it could ultimately limit access to appropriate services for vulnerable persons if sufficient flexibility is not built into the system from the beginning.

Service coordination, multidisciplinary care and rewarding outcomes demonstrating prevention, timeliness and quality of care

The ANF is generally supportive of the recommendations in relation to improving communication and health service coordination across the community. This must incorporate the need for community participation in the service coordination and population health planning through local Primary Health Care Organisations; as well as giving the community access to data on health service performance and any reasons for variations.

Regrettably, missing from the recommendations and not well articulated in the Report is the critical integration of primary health care services with other health services such as acute hospital services, aged care services and the proposed sub-acute services. Certainly, the flow of information and communication are critical elements in this, but the potential for the current 'cost shifting' lament to be carried over into the boundaries that divide these services is self-evident. This is especially so, as the jurisdictional boundaries of the services will be even more definite than they are now.

Primary Health Care Organisations

Recommendation 20 proposes the 'tweaking' of existing Divisions of General Practice and morphing these into Primary Health Care Organisations. The ANF is strongly of the view that any such organisation developed to support primary health care services should be built from the ground up; based upon a strong philosophy of primary health care and person-centred care; not on the organisational and administrative structure to support private general medical primary care practice.

Other related issues in primary health care

The broad community use of complementary/alternative therapies is not addressed in the Report; yet the co-existence of this important mode of primary health care delivery is clearly taken up in the community. Unless there is a more open relationship and an understanding of the interactions of the different therapies and treatments, this parallel primary health care system will continue to create distortions for the mainstream health system that could have extraordinary and unforeseen consequences.

Ignoring the use of complementary/alternative therapies is ignoring the community's opinion and confidence in it (or lack of confidence in the mainstream health system). It also highlights a level of disrespect for the community view. The Report makes a strong argument for ensuring community engagement is part of the planning, policy, service delivery and evaluation of the health system.

RECOMMENDATIONS 22 – 26: Nurturing a healthy start

The proposals concerning the health promotion, prevention, care and treatment strategies contained in this suite of recommendations is strongly supported by the ANF. This is an area where nurses and midwives have had a long, important and largely unacknowledged role in the past. There is no doubt, that with more rational funding arrangements and the capacity to work in much more collaborative transdisciplinary primary health care teams, their potential to contribute even more significantly in this area is enormous. This is clearly an area where nurse practitioners have great potential. The ANF is of the view that such a shift in emphasis is required to build sustainability into our future health system.

There is clearly a need for much more discussion and detail around: the concept of '*progressive universalism*'; how this concept would fit with *Medicare Select*; and how it is determined (and by whom) that a child/their family requires universal, targeted or intensive care.

RECOMMENDATIONS 27 – 36: Ensuring timely access and safe care in hospitals

The ANF is supportive of improving timely access and safe care in hospitals. However, we do have some qualifications in relation to some of the recommendations. For example the access target list provided in Recommendation 27 is not exhaustive and the proposal that they be developed further using community participative mechanisms such as citizen juries is regarded by the ANF as a vital early and next step.

RECOMMENDATIONS 37 – 41: Restoring people to better health and independent living

The ANF supports the proposals to enable transitional and sub-acute care arrangements. The integration of these services with acute hospital services, primary health care services and aged care services will be the challenge; ensuring that they do not become a second class of service and that there is a smooth transition between this service and the other services as required.

RECOMMENDATIONS 42 – 53: Increasing choice in aged care

Integration of aged care with other health services

The ANF remains deeply concerned about the fact that the nexus of aged care with other health service sectors is not well addressed in the Report. The isolation of aged care services – both in the community and especially residential from the broader primary health care strategies has been deplorable. Some of the recommendations for sub-acute transitional care, advance care planning and Recommendation 52 do go some way to addressing the difficulty that aged care service providers and carers have in ensuring comprehensive primary health care services for those people in our community who are the most vulnerable and who have the most chronic and complex care needs. The ANF, however, does not see the current gaps and barriers to high quality care being alleviated.

The provision of health services in settings where people are having to access assistance to help them manage the conditions of ageing has to be obviously connected and become a central feature of health policy in Australia rather than an annex, as it appears to be in the Report.

Multidisciplinary care for older people

There is a growing body of evidence building around the benefits of nurse practitioners working in aged care but support for this as an option is not mooted in the Report.² Physiotherapists and other health professionals working in primary health care outreach models of service delivery in atypical aged care services are also demonstrating the benefits of integrated primary health care provision in keeping older people healthier. Sadly these services are inequitable, as they are often provided at direct cost to the resident or client and as such are only available to those who can afford them. Aged care is the perfect setting to demonstrate the benefits of person centred care and taking the services to the client, either in community, respite or residential care settings. Currently it is easier to medicate than provide necessary interventions.

Technology and aged care

Better provision of primary health care services and the use of technology such as access to telehealth services would reduce the disorientating and disturbing experiences for people having to go to acute hospitals for investigations and therapy. The experience of dislocation and poor outcomes when this occurs is legendary. For example, the pressure ulcers that develop when a person is left on a trolley in the emergency department for hours on end and the confusion and distress when a person is moved into a foreign (and often frenetic) environment are daily stories heard in families, aged care services, and in the media.

Research and continuous improvement

Although aged care is highly regulated in Australia there are few incentives for continuous quality improvement, quality consumer outcomes, consumer satisfaction and success in this sector. The measure of success currently is by a client or resident's care needs increasing and hence their funding allocation being increased – a truly perverse incentive.

Aged care is an area where there is just as much need to evaluate therapeutic interventions, critically analysing the effectiveness of clinical interventions, as it is in multidisciplinary sub-acute care. There is much to be gained from tailoring resource utilisation to functional and psychosocial needs in order to support and increase functionality and quality of life rather than merely responding to acute health crises and needs. The ANF suggests that many people will begin to express this wish as and when advanced care planning becomes a feature of ageing and the management of chronic, complex and terminal illnesses.

Funding in aged care

Nursing care is the concern of the ANF. Care costs should be fully subsidised and separated from accommodation costs. Accessibility is an important aspect of accommodation costs and as such the maintenance of a basic subsidy for all is vital. The funding structures in aged care do not provide opportunities to be creative in brokering more needs based care and services. There is evidence to show that there are providers at risk of closure because their running costs are higher than their income – this is not an environment which encourages innovation and improvement.

Transparent and accountable funding arrangements must be implemented. A single funding stream across the health and aged care services would help with prioritisation and access issues. Program managed funding is also a consideration for enabling greater equity and access to service provision. The Aged Care Funding Instrument (ACFI) should be used in community care as well as residential aged care to ensure consistent assessment across the continuum of care. Money should follow the resident or recipient of care irrespective of location in the system (community or residential).

One of the primary workforce issues in aged care service provision in 2009 is the inequities in pay and conditions for nurses and other workers in aged care. Aged care is not and will not be seen as a mainstream career choice for nurses and nurse practitioners while this sub-class approach to workforce planning, remuneration and recognition continues. This is not canvassed at all in the Report. Care subsidies must be quarantined for nursing and spent on staffing and skill mix. Worker substitution should not be used as a replacement for qualified nurses.

Given the ageing of the baby boomers in Australia and the clear demand for creative solutions and care models for services and care for people as they age, this sector should be a thriving hotbed of research, innovation and growth, rather than the add-on it remains.

RECOMMENDATIONS 54 – 57: Caring for people at the end of life

The ANF supports all steps that will enable people to die with dignity, being provided with the care options of their choice by competent and respectful care givers.

FACING INEQUITIES

Recognise and tackle the causes and impacts of health inequities

RECOMMENDATIONS 58 – 64: Closing the health gap for Aboriginal and Torres Strait Islander peoples

The ANF gives strong support to the proposal to significantly increase levels of investment in health and capacity building for Aboriginal and Torres Strait Islander peoples. The proposal to establish a National Aboriginal and Torres Strait Islander Health Authority (NATSI) as a statutory body is also supported, as long as it is under the control of Aboriginal and Torres Strait Islander peoples. The development of the NATSI Health Authority has the potential to replicate the efficiency of the existing Department of Veterans' Affairs (DVA) system. Using the DVA central planning and funding allocation model could also make access to services more equitable as well as creating a better network of services. This should strengthen the primary health care approach, and possibly prevention measures although details in the Report about this role were scant.

The ANF considers that these initiatives will only be successful if implemented within the context of a long term plan for achieving health and social equity. We agree unequivocally that a whole of government approach is required to address the social determinants of health. As noted above, there has to be as much focus on these as there is on improving health services. Regrettably the Report did not deal with these in any detail, nor did it provide direction or suggest drivers for such changes, other than to suggest the Office for Aboriginal and Torres Strait Islander Health (OATSIH) could play a role.

There is strong support for Recommendation 59 which is in favour of the model of Aboriginal community controlled primary health care services; and the strengthening and extension of these services. This should increase access to culturally appropriate care whilst a stronger (but still culturally sensitive) accreditation focus could improve quality of care and associated outcomes.

The ANF also strongly supports the proposed increased focus on building a robust workforce of Aboriginal and Torres Strait Islander peoples. This workforce will assist in long term staffing of better resourced Aboriginal and Torres Strait Islander community controlled primary health care services sector and mainstream primary health care, acute, sub-acute and aged care services.

RECOMMENDATIONS 65 – 70: Delivering better health outcomes for remote and rural communities

The ANF strongly supports the proposal to provide rural areas with funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status. This will significantly increase access and will support the notion that areas should be funded on their populations' needs and not on the number of practitioners that currently choose to practice there.

We further support the expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000, although note this theoretically only increases the number of eligible towns by about 10%. However, the ANF is strongly in favour of the model of equitable funding with local flexibility to shape services. The integration of aged care, primary health care and sub-acute services in rural and remote areas is an imperative.

Also strongly supported is the initiative to address the current inequities and access disincentives relating to the travel and accommodation costs confronting people living in rural and remote areas by significantly increasing support payment schemes for health consumers and their carers. If services cannot realistically be brought to every consumer, then consumers and their carers should not be disadvantaged by their location. This has been a significant issue for consumers and carers for many years. The red tape for health staff associated with assisting consumers utilising support payment schemes currently also should be addressed.

The proposals for increased infrastructure and funding for health workforce education and training in rural areas and the establishment of a rural health research program are essential elements in improving the quality and sustainability of health services in rural and remote areas. Although these initiatives should strengthen the rural health workforce and ensure it is better able to meet the needs of rural and remote communities, the ANF is of the view that the recommendations do not go far enough to achieve the stated goals. For example, we would like to see additional measures to address the health professional shortage in rural and remote areas. The ANF sees that there is great potential for Nurse Practitioners and eligible midwives, in collaboration with other nurses and other health professionals, to play important roles in providing primary health care services across the varied settings that individuals and communities live in, in rural and remote areas, working with multidisciplinary teams using electronic and other contemporary forms of telecommunications, telehealth and transport for advice, support and referral purposes.

The ANF would especially like to see a greater focus on preventive health care and early intervention strategies in rural communities than is included in the Report.

RECOMMENDATIONS 71 - 82: Supporting people living with mental illness

All the initiatives outlined in the recommendations designed to improve the provision of appropriate, timely and safe mental health and dementia care services for people requiring them in primary health care, acute care, sub-acute care and aged care settings, by competent health professionals, are all strongly supported by the ANF and viewed as requiring urgent attention.

It is noted these recommendations do pick up on the immensely important social determinants of health for people experiencing mental health issues such as: supported housing, vocational rehabilitation and post-placement employment support. However, there is not enough emphasis on the integration of mental health services with meeting a person's physical health needs, which is a major gap at present.

Young people often either miss out on services or tend not to access them. It is encouraging to see services targeted to meet the needs of youth. However, given the significant investment in the *Headspace* model, an evaluation of this model is recommended before further investment in youth services. This needs to occur before developing alternate or adjunctive services to ensure they meet the needs of the sector.

Early intervention services are often spoken of in relation to youth and adolescents. This important initiative requires a national approach and investment, which a centre maybe able to provide. The ANF considers that early intervention in the person's journey needs to occur irrespective of age and across the mental health disease spectrum.

Development of outreach teams is required which will necessitate the development of additional services to support these teams. The focus of these teams should be broader than only for those experiencing psychosis. As an example, individuals with a diagnosis of personality disorder are best treated in the community and require acute services as well. In addition, co-occurring conditions such as alcohol and other drug use problems exist in tandem with mental health problems - this is the rule rather than the exception. It is important that any service specifically earmarked for individuals experiencing 'psychosis' does not exclude service users because they have co-occurring alcohol or other drug issues or other mental or physical health problems.

RECOMMENDATIONS 83 - 86: Improving oral health and access to dental care

The ANF is unequivocal in supporting a comprehensive universal dental care system in Australia. For too long the disastrous consequences of inadequate, inequitable and inaccessible oral health services have been impacting on people's lives and general health.

While the ANF does not regard this as optimal, we acknowledge the need for the 0.75% increase in the Medicare Levy to fund a universal dental scheme. The ANF also supports the option for all consumers to access a public dental health plan. Internships for all oral health graduates are seen as a useful transitional step and are welcomed in the short term. The broadening of the dental programs for kindergartens and schools is welcomed.

However, the ANF also has some serious misgivings about some aspects of the proposals outlined for 'Denticare Australia'. The ANF is of the view that Denticare should increase equity to dental services through increased access and a reduction in co-payments, but this will be compromised if people choosing public dental plans have to wait longer for care than those with private plans. We also have concerns that the issue of workforce distribution has not been addressed. Dental services are needed where the population is located and hence demand is often not where dentists choose to practise. In addition, basing the proposals upon services being provided by dentists working in private practice, who almost universally practice outside of the mainstream primary health care system, will continue the isolation of oral health from the mainstream health system and miss the opportunity for integrated care.

The ANF has significant concern too about the recommendations for the key role of private health insurance as a vehicle to facilitate access to services. This is inherently more expensive and less equitable and further complicates the already complex funding models in the health system.

It is the view of the ANF that all hospital services should provide opportunities for individuals to be linked with a range of community services and health professionals. Without the appropriate access to a range of community services, such as housing, sub acute services are likely to become an extension of acute hospital services. In theory, components of this type of system already exist. It is important to determine what has worked and what has not worked. The ANF considers that funding and workforce are core issues.

An increased awareness of mental health issues across all sectors of the health workforce is a welcome recommendation in the Report. The development of national curricula and national accreditation will support this recommendation. The provision of primary health care education and modules will assist in up-skilling the primary health care workforce.

The 4th National Mental Health Care Plan has been developed in consultation with Government Departments involved in the provision of support services such as the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Education, Employment and Workplace Relations (DEEWR) and other sectors. However, currently there is no process for commitment from the other sectors to ensure there is agreement on funding and modelling of these services.

Social supports and vocational rehabilitation should not just be allocated to those who suffer a chronic mental illness. The ANF sees that the aim should be to link those with a mental illness persistent over a period of time to services (whatever they may be) to ensure they do not develop a chronic long term mental illness.

As a society we are living longer and as such require good health care into old age. This includes good mental health care. Access to appropriately qualified staff in aged care facilities is an issue with fewer registered nurses available to provide health care and insufficient staff overall. Access to good mental health care is limited. Mental Health Nurses (both registered nurses and nurse practitioners) would be able to provide the services required if the appropriate structures were put in place.

The recommendation on recognising compulsory treatment orders across jurisdictions is long overdue. Transporting individuals under 'orders' is fraught with difficulty under the current arrangements: for the individual consumer, their carer and the staff involved. Developing mutual recognition arrangements between states and territories would assist greatly in ensuring individuals are treated in the most appropriate location.

Regarding Recommendation 80, health professionals currently do what they can to ensure safe discharge arrangements are in place. However, there is pressure on the system to discharge patients from the service and this in turn creates pressure to find alternate accommodation to the inpatient facility. The development of appropriate accommodation and support for individuals with a mental health problem will assist them to not forfeit their accommodation when they become unwell and, as such, to have stable accommodation to return to when they no longer require inpatient care. This is the responsibility of the system to ensure that the accommodation is available, not just of the health care professional.

The ANF would welcome a national community awareness campaign to reduce the stigma attached to mental illness. A considered national approach to the reduction of stigma within the health care and education system is also required. There needs to be a significant investment in programs to reduce stigma among professions such as the police service, the ambulance service and within broader but related fields.

The ANF considers that consultation needs to occur with consumers and carers to ascertain what they would consider to be the most appropriate mechanisms for them to be able to participate in feedback to shape programs and service delivery.

There is no reference in the recommendations from the *Supporting people living with a mental illness*, or *Closing the gap for Aboriginal and Torres Strait islander people's* documents, to address the mental health needs of Aboriginal and Torres Strait Islander peoples. This may be considered in reference to general health. The need to improve the general health conditions of Indigenous people is well understood, however difficult this may be to achieve. There continues to be little mention of the serious need to address mental health issues. This of course needs to be considered within the broader picture of the social determinants of health.

DRIVING QUALITY PERFORMANCE

Leadership and systems to achieve best use of people, resources and evolving knowledge

RECOMMENDATIONS 87 – 90: Strengthening the governance of health and health care

RECOMMENDATIONS 91 - 97: Raising and spending money for health services

It is a firmly held position of the ANF that there should be one overall funder of the system.

The model proposed of an incremental approach to a single funder means that the Commonwealth retains an interest in effective prevention of ill health, and primary health care and addresses some, but not all, cost-shifting pressures. Under this model, funding would still require continuation of two bureaucracies. One potential flaw is that the Commonwealth will pay for the 'efficient cost of care', based on casemix. This leaves the States to pick up the cost of any inefficiency with ongoing blaming about the right price and underfunding by the Commonwealth.

However, although the proposed models retain universality of access theoretically, neither of the governance recommendations addresses distribution of either health funding or services according to need.

The ANF supports some of the stated aims for 'Medicare Select', including promoting greater consumer choice and improving the use of health care resources. However, we have serious concern that the direction outlined in the Report for 'Medicare Select' will not achieve these aims and instead will result in a reduction in the overall equity and efficiency of our health system. It is notable that the 'Medicare Select' system is the antithesis of the WHO approach to health service provision.

The ANF supports increasing consumer choice within the health system and empowering consumers to make optimum health care decisions. However, we do not agree that 'Medicare Select' would necessarily provide increased choice to consumers and in reality may even reduce choice for many consumers, particularly those with limited resources and/or those most at risk of health problems. We also believe that there is considerable scope within the existing Medicare system to increase consumer choice and empowerment. One example of how this could be achieved is through extending Medicare funding to a broader range of services, including nursing, midwifery, allied health and preventive health care, and through targeted strategies to improve access to care to those currently under-serviced by Medicare (for example people in rural areas).

While the ANF understands the Commission's view that Medicare Select *"would encourage plans to find more innovative ways of delivering and funding the highest quality care. If they did not, they would find it hard to attract and keep members..."* we do not accept that the proposed system would achieve this aim or that increasing the role of the private sector is the best way of delivering innovation or greater efficiencies. Neither private health care providers nor private health insurers have a positive record of addressing inequities in access to health care or in driving innovation in health care delivery. In fact, private health services are often the least accessible to those most at risk of health problems in the community, such as people on low incomes, those in rural and remote areas and those with disabilities. If the role of the public health sector is reduced through 'Medicare Select', the ANF is concerned that access to health care for these groups will be further compromised. We also note that historically, most innovations in health and medical care have occurred in the public system and have then been adopted at a later stage by private providers. The ANF therefore has serious concerns about the capacity of the private sector to deliver the potential gains claimed by the NHHRC.

Similarly, the ANF is sceptical of the claim that 'Medicare Select' would improve the efficiency of health care delivery by stimulating *"health service providers to deliver the highest quality for the most efficient price."* We note that there is no evidence currently that private health services are more efficient than public health services and that there is considerable evidence that Medicare, as a universal insurer, has significantly reduced operating costs (as a percentage of overall funding) compared with private health insurers. The ANF does not believe that the NHHRC provides convincing evidence that the increased administrative costs associated with establishing multiple health plan operators under 'Medicare Select' would be outweighed by potential gains in efficiency.

The ANF is concerned that the NHHRC has not outlined any mechanism for attracting providers to areas currently under-served. This includes geographical areas such as many rural communities and areas of workforce shortage, such as aged care. Giving consumers an entitlement to funding without also providing them with access to services is meaningless. There are already inequities in access to many publicly funded programs in rural communities due to a lack of service provision, including Medicare, the PBS and private health insurance rebates. 'Medicare Select' risks compounding these inequities, through attaching funding to consumers who have little or no ability to attract providers to areas of need.

The ANF is also concerned that 'Medicare Select' will advantage those with the greatest resources and capacity to obtain information about their health care options and disadvantage those who are marginalised and who have limited resources. For example, to make an informed choice about what plan is best suited to their needs people will need to have a good understanding of their own health and their best care options. Those with a limited capacity to access information about their health care options, including people with low levels of literacy, limited access to sources of information, such as the Internet and people with mental illnesses and some forms of disability, are likely to find it much more difficult to make an informed choice.

In particular, the ANF is concerned about the potential for marginalised groups to be further disadvantaged as a result of their small market share. If insurers are competing with each other to offer services, they will pick those services which bring in the most members. While this may result in improved services for those with common conditions and/or groups which are easy to target (for example, young healthy people), it will be at the expense of services to those with less common conditions or people from groups which are difficult to access (for example, the homeless, people with intellectual disabilities and people with limited English comprehension).

Furthermore, the ANF notes that Medicare Select is a costly reform option, compared with other options canvassed in the Commission's Interim Report. Because hospital admission for surgery is a clear, discrete, easily measurable item, it is possible that Medicare Select could improve waiting times, as similar schemes have in other countries. The rest of the health care system will suffer.

Overall, the ANF is extremely concerned that the proposed Medicare Select could lead Australia down the path towards a two-tier health care system where the well-off receive higher quality care than those with limited means. We believe that in developing the Medicare Select proposal, the NHHRC has confused choice with equity. Greater choice for consumers must not mean more choice for those who already have it, and more restrictions to those whose choices are already limited. We would not support any proposal which resulted in the sickest members of the community having their health care limited to a basic package of care, while those who can afford it having access to a greater range of services.ⁱ

RECOMMENDATIONS 98 - 104: Working for us: a sustainable health workforce for the future

Supporting the health workforce

Recommendation 98 reflects many of the general outcomes of the three roundtable discussions that the nursing and midwifery Primary Health Care Working Group have held over the last 15 months and each is supported by the ANF.

Access to Medicare rebates, the MBS and the PBS

The ANF finds some of the elements of Recommendation 99 of concern. Except for the third dot point which we deal with separately, the ANF is strongly of the view that the statements should be standardised in such a way that the principles apply to all health practitioners, not specifically nurse practitioners. All health practitioners should work within the scope of their practice whether they are nurses, nurse practitioners, medical practitioners or other health professionals.

The ANF also has grave concern with the specific restraints outlined in dot points two and four. In dot point two, the requirement that the clients of nurse practitioners and unnamed other health professionals (but presumably not medical practitioners) should only have access to 'approved formularies' is creating an unnecessary duplication of a system of generic formularies that already exist under State/Territory regulation and policy, and local health service policy. Health professional regulation and the complaint/report provisions of the professional misconduct regime (Professional Services Review Scheme) are there to deal with the health professional who goes on a 'frolic of their own' and prescribes outside what is reasonable considering their scope of practice. There is evidence that unnecessary bureaucratic barriers such as creating another layer of formularies either reduces the appropriateness of care or requires unnecessary duplication of the care that can be provided to consumers.⁷ Dot point four requires that access to the Medicare Benefits Schedule should be restricted for (some) health professionals. As with the second level formularies this second level list could have perverse effects. There is already regulatory infrastructure to deal with health professionals who stray outside contemporary standards of practice.

The ANF reiterates that it does not support the delegated funding model proposed in Recommendation 99, for two reasons – the presumption that the medical practitioner will be the gatekeeper for care, treatment and referrals; and because it removes accountability from the person who is the direct provider of the care or service.

New education framework

The ANF generally supports most of the elements in Recommendation 100, with some qualifications.

The ANF takes the very strong view that transdisciplinary or multidisciplinary learning must be a comprehensive component of the educational socialisation of health professionals. This approach enables different professions to relate to each other, to gain a thorough understanding of each profession's expertise and competencies within all health care settings, and to develop trust and increase the capacity for different professionals to work together collaboratively in multidisciplinary teams. Transdisciplinary education programs at both horizontal and vertical levels are essential to achieve this. It is therefore of critical importance that clinical placements are organised so the different student groups work together, for example having mixes of nursing, midwifery, allied health and medical students undertake clinical placements together.

Working together with real people as case studies, learning how and when to refer and to communicate with other members of the health care team, including nurses, midwives, medical practitioners, physiotherapists, occupational therapists, psychologists and others is best done in the clinical setting.

In relation to the ANF's points of qualification:

Firstly, we have some concerns about the notion of a 'competency-based framework' as the concepts relating to competence, competencies and competency are not universally understood. For many a 'competency-based framework' means the model of training adopted in the Vocational Education and Training (VET) sector with education provided in a structured way by Registered Training Organisations (RTOs), rather than the standards based competencies that have been developed by different, generally tertiary prepared health professional groups, such as nurses and midwives.

Secondly, aged care is a serious omission from the health care settings listed.

Finally, health literacy and capacity building for health professionals to understand and provide genuine person-centred care with all the communication, information sharing and respectful engagement skills required, is an important component of any health education scheme. This goes hand in hand with health professionals learning the art of community engagement.

National Clinical Education and Training Agency

The ANF supports this recommendation on the proviso that it encompasses the education of all health professionals including medical practitioners.

RECOMMENDATIONS 105 - 114: Fostering continuous learning in our health system

The ANF supports all the recommendations in this part of the Report but has identified one serious omission that is not supported by recommendations in this part or any other of the areas in the Report. That is, the funding, education, research, capacity building and support for the community engagement initiatives that are clearly embedded in some parts of the Report.

No resourcing for community engagement indicates a lack of respect for this strategy as a credible initiative. While the support for the initiatives for improving health literacy across the community is laudable and necessary, this is only one aspect of community engagement. The effective use of the proposed citizens juries will require substantial commitment in the development of the model, its roll out and sustainability if these are to work and provide a cogent form of community engagement. Community engagement also needs to go across all sectors of health service delivery, prevention, health promotion, primary health care, sub-acute care, acute care and aged care.

Community engagement is required at a number of levels for it to be effective and provide a genuine opportunity for discourse and effective input to health policy development, planning and service design, service delivery and evaluation. It needs to happen at the level of the interaction in relation to a person's individual health and information needs; at local community level; local health service level; at regional community and health service (including state and territory) level; and at national level both in the health domain as well as at a cross-government level when deliberating on issues that are the social determinants of health outside the health domain.

RECOMMENDATIONS 115 - 123: Implementing a national e-health system

The ANF strongly supports the introduction of electronic systems within all health and aged care facilities across the country. Access to healthcare information through electronic systems will vastly improve the timeliness and quality of communication flows leading to enhanced outcomes of care for individuals. The recommendations under this section are therefore supported.

The assurance of privacy for individuals is paramount and is best enshrined in legislation which allows access to those who legitimately need to use the information for health care while protecting the individuals' interests.

The assigning of unique healthcare identifiers is an essential first step in the implementation of individual healthcare records systems. The ANF has provided input into the development of the unique healthcare identifier and has made submissions to the consultations by the Australian Health Ministers' Advisory Council in support of the legislation on Healthcare Identifiers.

The development and implementation of an appropriate national social marketing strategy is supported. However, it is essential to the success of a national e-health system that nurses and midwives are supported in gaining competence with new information technology and management, and of having access to and being resourced with, appropriate computing equipment in their workplace.

The success of e-health capabilities throughout the health and aged care sectors will be dependent on the familiarity of health professionals with the electronic infrastructure. It will be imperative that nurses and midwives constitute a substantial component of the communication strategy for the implementation of healthcare identifiers and electronic healthcare records management.

Access to electronic health systems is essential for all Australians regardless of geographical location. It is essential that e-health systems being developed and implemented at the jurisdictional levels for clinical communication articulate well with each other. A high level of semantic interoperability should be considered a priority in the development and adoption of clinical information systems to ensure that the clinical information will be able to be shared between different health professionals.

Given that nurses and midwives constitute more than fifty percent of the health workforce, clinical systems being implemented must reflect the needs of nursing and midwifery clinicians, in terms of capturing data that reflects their contribution and subsequent patient outcomes. The clinical needs of nurses and midwives and their workflow issues must be fully considered when acquiring, designing, implementing or upgrading information technology and information management systems under e-health initiatives. In order to do this, nurses and midwives must be involved at all stages, including associated planning, evaluation, trialing or piloting, workflow review, and in the development and implementation phases for education and communication strategies.

The ANF considers that the shift to electronic health records is likely to have a significant impact on the immediate future working environment of nurses and midwives; it is likely to have substantial effects on the way care is delivered; and affect the future skills mix of the nursing and midwifery workforce. It is vital that nurses and midwives remain engaged with the issues associated with the development and roll-out of clinical communications systems to ensure the unique disciplines of nursing and midwifery, and their interventions and associated outcomes, are accurately captured by the clinical information systems being implemented.

There is a need to engage expert nurse and midwife clinicians in the e-health agenda. Nurses and midwives must be represented on all institutional and jurisdictional committees developing e-health standards and practice guidelines. Organisational policies should ensure that, during the course of their employment, nurses and midwives have appropriate and timely access to the technology and software necessary to undertake their roles.

As the largest health professions in the health workforce, nurses and midwives manage client information continuously and it is critical they are familiar with the information technology and management systems for e-health initiatives such as clinical decision making, health care records and care plans.

It is essential that there is a coherent national strategy for capacity building and education of health professionals concurrent with the roll-out of clinical information systems. The nursing and midwifery professions, as the major user groups of e-health technologies, can greatly influence the efficacy and implementation of systems in health and aged care settings. Engagement with the nursing and midwifery professions by key stakeholders in the e-health agenda is imperative to ensure successful use of e-health systems for the benefit of health and aged care professionals and consumers. There must be a significant investment in IT education and training for the nursing and midwifery workforce to upgrade their skills and knowledge using a system such as the international computer driving license to assist nurses and midwives to become competent in the use of electronic clinical communication systems.

It is important that tertiary nursing and midwifery education providers include informatics at both undergraduate and postgraduate levels. Providers of nursing and midwifery education should be given support to continue to provide informatics content within core content of undergraduate curricula as well as to offer postgraduate studies to build unique expertise within this specialty in Australia. The move to national registration and accreditation should be utilised to seek the inclusion of health informatics in nursing and midwifery curricula core content. There also needs to be additional health informatics experts available to support the education of all health professionals and the implementation of the e-health agenda more broadly. To this end the ANF supports capacity building of this sector of the health workforce through the increase of tertiary education courses for health informatics.

Development of a National E-Health Action Plan and the establishment of a national health knowledge web portal are supported by the ANF. In the interests of safety and quality use of medicines, the introduction of nationally consistent electronic prescribing and medicines management should be given high priority. The successful implementation of a National E-Health Action Plan will depend on improved access to, support and training of, nurses and midwives, in information technology and management systems and improved consultation with these health professionals when e-health systems are being implemented in health or aged care.

CONCLUSION

The ANF is in absolute agreement with the Commission that *“the case for health reform is compelling”*.¹ ANF nurse and midwife members experience each day the effects of system inefficiencies and pointless blame games between different levels of bureaucracy. There are gaps in service provision; needless duplication of services; people who don't or won't access mainstream health services; and, a lack of effective communication processes between all levels of the health and aged care systems.

The ANF supports many of the initiatives and recommendations detailed in the NHHRC Report as outlined in this paper. The move towards a more national system; the increased focus on primary health care; recognition of the imperatives and priority of improving health outcomes for Aboriginal and Torres Strait Islander peoples; greater nurturing in the early years; stronger rural health services; and the new initiatives in dental health and mental health are all welcomed as important areas for reform. The support for some of these recommendations is with qualification however, about the suggested approaches for rectification.

The desire for greater efficiencies in the expenditure on health and aged care is laudable. However, the ANF cautions that care must be taken not to institute measures which will prove to be false economies. The development and introduction of reforms to realise improved quality of care must put the needs of consumers of health and aged care at the front and centre of initiatives; as well as include much needed support and investment in ensuring a skilled and appropriately resourced health and aged care workforce.

The ANF continues to monitor the proposals emerging from the Government on the development of health reforms. In particular we are interested in providing on-going advice on the details of plans for implementation, to ensure that the practical application of reforms best serves the interests of consumers of health and aged care services and the health professionals delivering those services.

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- i Acknowledgement is made that the information contained in this section is largely attributed to the analysis conducted by the Australian Health Reform Alliance (ACHRA) of which ANF is a member.