australian nursing federation

Submission to Department of Health and Ageing on Development of a Network of Primary Health Care Organisations (Medicare Locals) across Australia

September 2010

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1. Introduction

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

As the largest professional and industrial organisation in Australia, the ANF has a membership of over 190,000 nurses, midwives and assistants in nursing, who are employed in a wide range of settings in urban, rural and remote locations in both the public and private sectors.

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

The ANF participates in the development of policy relating to nurses and midwives on issues such as: practice, professionalism, regulation, health and aged care, community services, veterans' affairs, education, training, workforce, socio-economic welfare, occupational health and safety, industrial relations, social justice, human rights, immigration and migration, foreign affairs and law reform.

In its submission to the External Reference Group for the National Primary Health Care Strategy in 2009, the ANF applauded the Australian Government for putting the spotlight on primary health care and gave strong support to the development of a national primary health care strategy. It is the view of the ANF that positioning primary health care at the centre of health policy in this country should lead to significant improvements in health for all Australians across their lifespan.

2. Potential Boundaries for Medicare Locals

Primary health care is fundamental and inherent in the philosophical base of nurses' and midwives' practice. With its large membership of nurses and midwives the ANF has a critical interest in infrastructure development of primary health care organisations (PHCOs) in terms of the composition of the health professional workforce, clinical leadership, the basis for boundaries, and, importantly, the range of services available and readily accessible to meet health and aged care needs of the community.

2.1 Principles for determining boundaries or catchment areas for Medicare Locals

The ANF proposes that the following principles be applied when determining boundaries or catchment areas for Medicare Locals or PHCOs.

Principle 1:
That PHCOs reflect primary health care in its broadest sense of health promotion, prevention of disease and injury and the diminution of health inequalities for all Australians across their lifespan.[1]

The ANF maintains a position that there is a difference between primary health care and primary care. In 2009 the ANF, as part of a group of leading nursing and midwifery professional organisations, developed a consensus view on primary health care in Australia which argued that: a) primary care and primary health care "generally represent two different philosophical approaches to health care", and b) primary care is a subset of primary health care.[2] These organisations agreed that the current health reform agenda in Australia "offers a unique opportunity to consider an enhanced model of primary health care that extends beyond the services of a general practitioner (primary care) to a multidisciplinary model to offer comprehensive, patient centred primary health care services".[3]

The nursing and midwifery consensus view supports the notion of difference between primary health care and primary care, as espoused by Keleher (2001)[4] who says that primary care is

> *Commonly considered to be a client's first point of entry into the health system if some sort of active assistance is sought. Drawn from the biomedical model, primary care is practiced widely in nursing and allied health, but general practice is the heart of the primary care sector. It involves a single service or intermittent management of a person's specific illness or disease condition in a service that is typically contained to a time limited appointment, with or without follow-up and monitoring or an expectation of provider-client interaction beyond that visit.*

In its position statement *Primary Health Care*, the ANF[5] maintains that "Primary health care acknowledges a social view of health and promotes the concept of self reliance to individuals and communities in exercising control over conditions which determine their health". Primary health care is seen by the ANF to be

> *…both an approach to dealing with health issues and a level of service provision. As an approach it deals with the main health problems and issues experienced by the community. It may include care and treatment services, rehabilitation and support for individuals or families, health promotion and illness prevention and community development.*[6]

This position by the ANF that primary health care is a broader model of person-centred, multidisciplinary care and not just medical care, is in line with that adopted internationally under the auspices of the World Health Organisation (WHO) as 'primary health care'.[7],[8]

The suite of health reforms initiated by the Australian Labor Government in 2008 provide an opportunity to broaden Australia's health policy and funding strategies from a narrow focus on hospital based care and the treatment and cure of already established conditions to health promotion and early intervention to prevent disease and injury within a primary health care milieu.[9] As the Australian nurses' and midwives' consensus view makes clear

> *The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must meet the health care, treatment, self management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care across the period of their lives.*
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> *A variety of responsive forms of service delivery, provided by a range of providers, including nurses and midwives must be available to meet the needs of all people, including those with special needs such as intellectual disability and cultural or language barriers; and giving priority to those most in need.*[10]

Given the foregoing commentary the ANF argues against the framework for development of Primary Health Care Organisations (PHCOs) being part of the existing General Practice networks as put forward firstly by the National Health and Hospitals Reform Commission[11] final report at Recommendation 21; and secondly by the PHCO Boundary Modelling Project by Carla Cranny & Associates Pty Ltd.[12] Embedding the PHCOs into the general practice network structure would negate the fact that primary health care is broader than primary care.

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.

Principle 2:
That policies and processes be developed to promote seamless integration for consumers of health and aged care services between primary health care and tertiary care.

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

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

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

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

The ANF has been a strong supporter of the implementation of an individual electronic health record system to facilitate rapid transfer of information across public and private facilities, primary, secondary and tertiary health care; and to provide a greater degree of transparency of a person's health records to all parties involved in that person's care – especially the person themselves!

The ANF applauds the focus of the Labor Government on investment in tele-health which will have enormous benefits for rural and remote areas so that health care professionals can utilise and facilitate consultations with appropriate specialist clinicians from the wide variety of disciplines operating within the primary health care centre/field, to greatly assist in clinical care leading to better outcomes for individuals and communities.

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

Principle 3:
The most appropriate health care professional at the time should take the clinical leadership role within the PHCO team.

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

For the future primary health care system to provide equitable access to cost effective care that delivers the best possible outcomes, much will depend on the successful establishment of collaborative relationships among all the health professions, and an increased emphasis on the delivery of care by multidisciplinary teams.

The team concept assumes that the problem being addressed is so complex that no one discipline alone possesses the expertise or information to provide all care. In a smoothly functioning multidisciplinary health care team, services are provided by an integrated group of professionals who coordinate health care services across a variety of disciplines. The team members work well together and believe that the combined contribution of the team is greater than any one discipline can provide. Team members from different disciplines work independently, collectively setting goals and sharing resources and responsibilities.[13]

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

The most appropriate health care professional at the time should take the leadership role. This will change depending on the circumstances – it could be the nurse, midwife, medical practitioner, or an allied health professional. In an interdisciplinary team, members work together interdependently to develop goals and a common treatment plan, although they maintain distinct professional responsibility and individual assignments.[14]

Principle 4:
That PHCOs convene stakeholder groups to undertake identification of community health and aged care needs and population health planning.

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

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

The disadvantage is the risk of a lack of consistency in the governance of primary health care services across the country; which may result in difficulties in standardising data collection. Standardisation is necessary for trend information to guide the policy formulation which underpins primary health care services. Lack of consistent governance may then lead to a risk of the continuation of the fragmentation of services across jurisdictions. There will need to be use of existing/development of new nationally consistent data collection tools to provide information for national planning on, for example, health professional workforce and education, federal health and aged care service funding, and long term projections and planning.

2.2 Suggestions about the optimum number of Medicare Locals in a particular state, territory or region, including potential boundaries in each area.

The ANF agrees with the view of Cranny and Eckstein (2010)[15] that "PHCOs represent a new entity in the Australian health system landscape with a wider range of functions than current GP Divisions or other primary care or community health services." In their subsequent commentary Cranny and Eckstein arrive at the conclusion that "PHCOs need to be large enough to operate as equal partners in the design and delivery of integrated models of care and to have real bargaining power in their relationships with Local Hospital Networks." The ANF supports this view. At the same time the ANF agrees with the National Rural Health Alliance[16] that Medicare Locals/PHCOs should not be so large that their relevance to the needs of local communities is lost. The input of the community, based on their particular needs, the monitoring of community health status and the fostering of innovation and sharing of research, are critical to developing appropriate models of care, improving services and the health of the people in that community. It is the view of the ANF that the role of primary health care services provided locally, by community health providers including general practices, should not be underestimated.

Given the diversity in size of the Australian States and Territories it does not seem appropriate to name an optimum number of Medicare Locals/PHCOs. What does seem appropriate is to start with the existing regional boundaries in the jurisdictions and determine numbers of Local Government Areas (LGAs) within these which could sensibly be drawn together to form the Medicare Locals/PHCOs, according to population size and links with Local Hospital Networks.

Use of existing boundaries as much as possible will expedite the process of establishing PHCOs and result in the least disruption to the re-organisation of the administrative infrastructure. Of critical importance will be that there will be minimal change for local communities already familiar with LGA boundaries.

The preference of the ANF would be to not have PHCOs crossing jurisdictional borders, except where cross border arrangements may already be in place, such as for the Albury/Wodonga or Tweed Heads/Coolangatta areas. It is important that new contractual arrangements for cross border jurisdictions are established with the implementation of PHCO's to ensure that appropriate funding models are linked to individual episodes of patient care and not money funded to the provider/organisation.

2.3 How boundaries might be defined in cross border areas.

Due to significant issues related to State funding arrangements and agreements involved in cross border relationships the ANF considers that it is preferable to confine these areas to those already in existence. That is, there should be no artificially created cross border areas for the purposes of PHCOs.

While registered health professionals now practice under national legislation, making movement across State/Territory borders easier for work purposes there are still factors which govern local practice which need to be considered in cross border discussions such as:

- differences in legislation, for example: State/Territory based public health legislation and State/Territory based drugs and poisons legislation,
- different industrial awards and conditions applying to employees.

It is worth noting that Point 2.2 and 2.3 above are particularly pertinent within the ACT where the major hospital – The Canberra Hospital (TCH) – has a catchment area in South East NSW with a resulting potential clinical population of 500,000. There is also a significant number of patients who routinely access services within the ACT, for example dialysis, from such areas as Queanbeyan, Yass, and Cooma.

2.4 Potential barriers or difficulties that will need to be addressed in establishing new boundaries and catchment areas for Medicare Locals.

The major barriers that will need to be addressed in establishing new boundaries are the existing contractual agreements that have been arranged between health agencies. For example, in Victoria Maternal Health and Child Nurses' services are currently located in LGA facilities, with specific roles and functions and industrial agreements that may not easily transfer to the Medicare Local/PHCO environment, particularly in the cross border arrangements.

There are also issues of:

- access to Medicare Locals/PHCOs especially for people who currently do not access mainstream health or aged care services
- the impact of the ageing society with associated chronic illness and disability
- managing the interface of the private business of general practice with the public sector PHCOs. As stated previously general practice is a sub-set of primary health care. To provide the most effective care across the primary health care sector it will be essential that arrangements are determined for facilitating the interface between general practice (which is private enterprise) and the PHCO (which is publicly funded and managed)
- integration of existing facilities which will ideally be required to work much more closely together to achieve the aims of comprehensive primary health care such as community health, bush nursing centres, private health care providers such as dentists and physiotherapists, local council services such as meals on wheels and provision of community aged care, and charity organisations.

3. Additional general comments relating to primary health care delivery

The nursing and midwifery workforce is currently an under-utilised resource in the primary health care arena. This is due either to restrictions on scope of practice or lack of recognition of role and function of nurses and midwives. The ANF considers that there needs to be a much greater utilisation of the nursing and midwifery workforce in order to ensure appropriate services for all geographical areas and population groups. Nurses tend to be the largest health care professional group across geographical areas – and in fact may often be the only health care professionals in remote areas. The Australian Government's Productivity Commission Research Report *Australia's Health Workforce*[17] provides a stark revelation of the fact that, unlike all other health professionals, nursing and midwifery numbers remain fairly constant relative to population for communities located further away from the major cities.

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

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

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

Policy development and provision of health services needs to be shaped around the promotion of healthy living, the prevention of disease, injury and disability; as well as meet the health care, treatment, self management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care across the period of their lives.[18]

In order to ensure the policies and processes are appropriate for communities it is important to remember that people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[19] Integral to this process is the involvement of both community members and health professionals as to their views on indicators of population-based preventive health care and thus what should be included in national reporting.

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

4. Conclusion

The ANF welcomes the opportunity to provide comment to the Department of Health and Ageing to inform development work on potential boundaries for Medicare Locals/Primary Health Care Organisations.

It is a strongly held view of the ANF that positioning primary health care at the centre of health policy in this country will result in significant improvements in health for all Australians across their lifespan.

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

The structure and boundaries of Medicare Locals/PHCOs will be critical in their ability to drive a central focus on primary health care in the health and aged care agenda for this country. The ANF looks forward to further participating in this pioneering work.

5. References

1. Consensus Statement *Registered nurse and nurse practitioner role in primary health care*. 2008. Available at www.anf.org.au
2. Ibid
3. Ibid
4. Keleher, H. 2001. Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. *Australian Journal of Primary Health*. 7(2): p 57-61.
5. Australian Nursing Federation, Position statement *Primary Health Care*. 2006 Available at www.anf.org.au.
6. Ibid
7. World Health Organisation (WHO). 2009. Primary health care, web page – Health Topics. Available at: http://www.who.int/topics/primary_health_care/en/
8. WHO and UNICEF. 1978. Declaration of Alma-Ata – Report on the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Available at: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
9. Consensus Statement loc cit
10. Ibid
11. National Health and Hospitals Reform Commission *A Healthier Future For All Australians – Final Report of the National Health and Hospital Reform Commission*. June 2009. Available at: http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report
12. Cranny, C. and Eckstein. G. 2010. *Framework for development of Primary Health Care Organisations in Australia. Australian General Practice Network Boundary Modelling Project*. Prepared by Carla Cranny & Associates Pty Ltd. Available at: http://yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/AGPNSubmission
13. Cooper, B.S. and Fishman, E. 2003 *The interdisciplinary team in the management of chronic conditions: has its time come?* New York: Institute for medicine Practice.
14. Young, C.A. *Building a Care and Research Team*. Journal of the Neurological Sciences. 160, S137-S140.
15. Cranny and Eckstein. 2010. loc cit. p. 21.
16. National Rural Health Alliance. 2010. Media Release: *Rural people want 'Medicare Locals' – not State-wide primary care agencies.* Issued 4 July 2010. Available at: http://nrha.ruralhealth.org.au/mediareleases/?IntCatId=16&IntContId=14844&Archive=Archive
17. Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra. p. 204-205.
18. Consensus Statement loc cit
19. Ibid