Queensland Nurses & Midwives' Union

Submission to

The Education, Employment and Small Business Committee

Health and Wellbeing Queensland Bill 2019

March, 2019

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Contents

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Education, Employment and Small Business Committee (the Committee) for the opportunity to make a submission to the inquiry into the *Health and Wellbeing Queensland Bill 2019* (the Bill).

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 60,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU**.**

Previous Submissions

In 2015, the QNMU made a detailed submission to the (then) Health and Ambulance Services Committee in which we signalled our support for the establishment of a Queensland Health Promotion Commission. In 2017, the QNMU made another submission to the Health Communities, Disability Services and Domestic and Family Violence Prevention Committee in which we supported the Health Futures Commission (subject to concerns around governance).

Given the very brief time provided for this inquiry, we have attached our previous submissions, reiterated our views on the importance of primary and preventative health measures and make recommendations in this regard. Of major importance to the QNMU is the composition of the Health and Wellbeing Queensland (HWQ) board. While we recognise the need for flexibility, we believe a registered nurse and midwife must be core members of the board.

Nurses and midwives work across all health sectors, geographic areas and settings. It is entirely appropriate their presence, contribution and expertise are recognised by permanent status on the HWQ board. No other health cohort has anywhere near the size, depth, breadth or influence as nursing and midwifery. No other profession holds the same level of public respect.

The bill proposes the membership of the board should consist of the following persons (each a ***board member***) —

(a) at least 1, and not more than 4, chief executives;

(b) at least 1, and not more than 6, other persons.

(2) A board member must be appointed by the Governor in Council.

(3) A board member mentioned in subsection (1)(b) must have qualifications or experience in at least 1 of the following areas—

(a) law;

(b) business or financial management;

(c) public health;

(d) academia;

(e) community service organisations;

(f) the not-for-profit sector;

(g) another area the Minister considers relevant or necessary to support the board in performing its functions.

It is inconceivable the permanent membership does not include a health practitioner, particularly a nurse or midwife. As the bill now reads, HWQ could potentially have no health practitioner on it at all. It is therefore both timely and necessary a nurse and midwife are appointed to this leadership role without equivocation.

Our submission also draws attention to the importance of midwifery care in developing the long-term health of the population, the health and wellbeing of the nursing and midwifery workforce and the relationship between HWQ and the newly formed Office for Prisoner Health and Wellbeing.

Recommendations

The QNMU recommends the bill be passed by the parliament subject to the following amendment to clause 18:

18 Board members

The board consists of the following persons (each a *board member*) —

(a) at least 1, and not more than 4, chief executives;

(b) at least 1 registered nurse and 1 registered midwife;

(c) at least 1, and not more than ~~6~~ **5**, other persons.

(2) A board member must be appointed by the Governor in Council.

(3) A board member mentioned in subsection (1)(~~b~~**c**) must have qualifications or

experience in at least 1 of the following areas—

(a) law;
(b) business or financial management;
(c) public health;
(d) academia;
(e) community service organisations;
(f) the not-for-profit sector;
(g) another area the Minister considers relevant or necessary to support the board in performing its functions.

The QNMU further recommends HWQ:

- operate independently of Queensland Health and have a broad remit to consider the social determinants of health extending beyond a narrow health policy framework;

- develop clear understandings of its role in primary health particularly given the ongoing debates around commonwealth/state funding;

- liaise with the federal government on matters requiring integrated policy work – primary care, mental health and aged care;

- consider ways to measure and evaluate progress in closing the service gaps in primary health care through more effective workforce planning, public education programs and whole-of-government policy initiatives;

- prioritise ways to:

    - increase better resourcing of perinatal preventative health strategies;
    - promote normal birth and breastfeeding as important measures to prevent long-term chronic disease;

- engage with the health workforce, their representatives, employers, community groups and the Queensland public as a first step in developing strategies promoting health and wellbeing through preventative measures;

- clearly articulate the relationship between the Office for Prisoner Health and Wellbeing and HWQ given prisoner health is also a public health issue;

- engage with nurses and midwives, their representatives and health and safety representatives regarding workplace health and wellbeing.

Primary Health

The QNMU supports the establishment of HWQ as a significant preventative health measure. This is a timely initiative given primary care is the foundation of our health care system, however, increasingly for patients, doctors, nurses, midwives, allied health practitioners and indeed taxpayers this foundation is under stress. This is due in part to the contested nature of funding arrangements and responsibilities between the states and the Commonwealth government. This correlation will be an important influence in determining the scope of HWQ's functions.

In our view it is essential HWQ operates independently from Queensland Health and has a broad focus beyond the traditional health portfolio area. Its sphere of activity should explore the key social determinants of health and recommend innovative strategies for improvement.

A Canadian review (Hutchison, Levesque, Strumpf & Coyle, 2011) outlined a number of key findings in relation to the characteristics of an optimal primary health care environment:

- Interprofessional primary health care teams;
- Group practices and networks;
- Patient enrolment with a primary care provider;
- Financial incentives and blended-payment schemes;
- Development of primary health care governance mechanisms;
- Expansion of the primary health care provider pool (e.g. nurses and midwives);
- Implementation of electronic medical records;
- Quality improvement technology, training and support.

In Queensland, the most serious gaps in the primary health system exist for patients requiring highly specialised and diverse health care such as patients experiencing mental illness, particularly in the category of child and youth, disability and domestic violence.

Service gaps in primary health care are more prominent in indigenous communities as demonstrated by the limited progress against the life expectancy target reported within the *Closing the Gap Prime Ministers' Report 2019* (Australian Government, 2019).[1]

Access to appropriate primary health services for culturally and linguistic diverse communities and refugee communities remains an issue as does the ability to sustain the presence of primary health in regional, rural and remote areas.

[1] The target to close the gap in life expectancy by 2031 is not on track. Between 2010–12 and 2015–17, Indigenous life expectancy at birth improved by 2.5 years for Indigenous males and by 1.9 years for Indigenous females (both not statistically significant), which has led to a small reduction in the gap.

The reasons for service gaps in the primary health care system include but are not limited to:

- Lack of health service integration;
- Limited patient coordination;
- Inability for clinicians to work to full scope;
- Limited access to the Medical Benefits Scheme (MBS) for nurses/midwives;
- Inadequate health workforce planning;
- Ineffective health policy/strategic direction;
- Insufficient funding/prioritisation;
- Minimal evaluation and public reporting;
- Geographical location.

The effectiveness of collaborative, whole-of-government, approaches for improving and sustaining health and wellbeing

In recognition of the need for joint action where the most important determinants of health are found in sectors other than health, the World Health Organisation (WHO) (2011) promotes 'smart' governance through new independent agencies and expert bodies that combine whole-of-government with whole-of-society approaches. The QNMU believes the proposals identified by the WHO could guide the role, scope and strategic direction of HWQ. These include governing through:

- collaboration;
- community engagement;
- a mix of regulation and persuasion;
- independent agencies, adaptive policies;
- resilient structures and foresight.

Independent expert bodies such as agencies, commissions, regulators and auditors are playing increasingly vital roles in providing evidence, maintaining ethical boundaries, extending accountability and strengthening democratic governance in health (World Health Organization, 2011). HWQ could encompass these roles as well as providing quality control and health impact assessments.

The importance of these functions increases with the move towards a knowledge society with rapid innovation. Health and wellbeing promotion must include objective and subjective measures to capture progress and enable public scrutiny. Given the long-term nature of many health conditions, anticipatory governance also requires new forecasting methods. A wide variety of interventions at local and community levels such as school

based youth health care, midwifery and post-natal care can increase social resilience and address more fundamental systemic challenges.

Emerging approaches and strategies

The 'health and wealth' agenda is based on the scientific evidence that health is an investment, not just an expenditure. Healthier populations are more productive, participate more actively in the labour market and gain higher incomes (McDaid, Drummond & Suhrcke, 2008; Suhrcke, Lorenzo & McKee, 2007; Suhrcke, McKee, Sauto Arce, Tsolova & Mortenson, 2005).

There are many lessons to learn from Denmark, a world leader in health care. Long before others, Denmark radically transformed its model of health care to become financially sustainable for the multiple challenges ahead. While other countries have been responding to growing demand by building more hospitals along traditional lines, the Danes have been reducing them (Margo, 2019).

In 1999, Denmark had 98 hospitals. Today it has 32.

All first-world countries are facing the same challenges from an ageing population with more chronic disease among a fast-food generation with lifestyle issues that lead to chronic illness. At the same time, more informed patients are expecting higher cost treatments.

The Denmark model aims to deliver as many services as possible through primary healthcare, municipalities, health centres and outpatient clinics and as little healthcare as possible from hospitals. The philosophy is to handle all other kinds of problems through primary care and add to the stronghold of the GP, municipalities and clinics (Margo, 2019).

All registered Danish residents are automatically entitled to publicly financed health care, which is largely free at the point of use. Health care is financed mainly through a national health tax, set at 8 percent of taxable income. Revenues are allocated to regions and municipalities, mostly as block grants, with amounts adjusted for demographic and social differences; these grants finance 77 percent of regional activities (Vrangbaek, 2016),

In Denmark the GP is the gatekeeper of healthcare, concluding nine out of 10 issues that arise. A map of speciality hospitals has been drawn up across the country and doctors and the ambulance services know whether the patient should go to specialised orthopaedic, cancer or cardiac hospitals (Margo, 2019).

Another model of delivering high levels of patient satisfaction and high staff satisfaction is the Dutch Buurtzorg organisation (Buurtzorg, 2017; Drennan, Calestani & Ross, 2018). This social enterprise organisation uses a patient-centred model of care combined with self-managing teams of visiting nurses. A central tenet is 'humanity over bureaucracy', that is, giving authority and responsibility to the frontline nurses supported by small functional back office support without creating tiers of management and associated expensive overheads such as offices (Kreitzer, M., Monsen, K. , Nandram S. et al., 2015).

This patient-centred model prioritises relationship-based practice with continuity in nurse provider (in contrast to tasks split between different grades of staff or services) and is directed at empowering patients (Kreitzer, Monsen, Nandram et al., 2015). A review of the Dutch evidence and applicability to the USA reported 'Buurtzorg has earned high patient and employee ratings and appeared to provide high-quality home care at lower cost than other organizations' (Gray, Sarnak & Burgers, 2015, p. 8).

The Buurtzorg model has attracted interest in many countries including the UK (de Blok, 2015) where there are acknowledged problems in both meeting demand for these types of services and also in attracting and retaining nurses to work within them (Maybin, Charles & Honeyman, 2017).

In Australia, Menadue (2019) has also drawn repeated attention to the importance of developing healthcare services in the community and so relieve the pressure on hospitals. We suggest HWQ could look to the Denmark and Dutch experiences for initiatives in transforming primary health care.

Nursing and midwifery in Primary Health Care

As the largest clinical workforce, nurses and midwives play a significant role in leading and driving patient-centred improvements across the health system. Nurses and midwives are appropriately regulated, educated and competent to lead and participate in the delivery of primary health care and are known to be proficient in providing holistic health services that directly meets the core principles of primary health care including:

- Patient/family/carer advocacy;
- Individual process of care;
- Educating, enabling and supporting self-management;
- Leading and coordinating multidisciplinary care;
- Leading and participating in quality improvement.

In Queensland, there are several nurse-led chronic disease services working in collaboration with multi-disciplinary team members to provide effective and efficient chronic or complex

care within Hospital and Health Services. These services have produced a variety of constructive outcomes for patients, communities and health services.

The introduction of Nurse Navigator positions has been a positive means of addressing the current difficulties in accessing and traversing the health system. This is just one practical method of giving people more information and ultimately better care.

The QNMU considers there are significant opportunities for reform in the nursing and midwifery health workforce that will assist HWQ in its primary health care goals. This will involve the development and operationalisation of strategies that enable nurses and midwives to:

- work to their full scope of practice across all settings;
- expand the delivery of nursing and midwifery across the healthcare system to increase service capacity and consumer choice;
- increase nursing and midwifery services to improve the effectiveness and efficiency of the healthcare system;
- provide high-performing nursing and midwifery services through continual learning and evidence-based practice; and
- enhance patient/consumer care through access to appropriately designed data sets and information systems (Queensland Health, 2013; Altman et al., 2016; Institute of Medicine of the National Academies, 2010; Coalition of National Nursing and Midwifery Organisations, 2017; Fairman et al., 2011).

A fundamental reform priority is to expand the public/private service provider frameworks and funding models to include registered nurses and midwives, particularly in the areas of Pharmaceutical Benefits Scheme (PBS), Medical Benefits Schedule (MBS) and private insurance schemes. The inclusion of registered nurses and midwives in public/private service provider frameworks will increase the capacity of healthcare services to meet consumer demand by reducing the preferential financial support for medical models of practice over nursing and midwifery models of care.

Primary midwifery as a public health strategy

Increasingly, the health system is engineered to encourage medical intervention in birthing, a practice exacerbated by activity based funding and one which undervalues midwifery.

There is emerging evidence some birth interventions may have an effect on the neonatal immune response and the child's health in the longer term. Normal delivery and breastfeeding are evolutionarily adaptive processes paramount to human newborn development and health. Common perinatal interventions like caesarian-sections, antibiotic

use, and formula feeding alter the infant microbiome and may be major factors shaping a new microbiome landscape in human history (Mueller et al., 2015).

Epidemiological evidence suggests these impacts on the early microbiome assembly are associated with metabolic and immune pathologies. Even if antibiotic use, caesarian-section delivery, and formula feeding are only marginally associated with disease risk at the individual level, the widespread use of these practices may contribute to considerable disease burden at the population level.

There is a global awareness caesarean delivery rates are too high. A recent study (Peters et al., 2019) on the association between medical birth interventions and/or operative birth interventions on short-and longer-term child health outcomes in healthy women and their children showed children born by cesarean delivery were at a statistically significant increased risk for infections, eczema, and metabolic disorder, compared with spontaneous vaginal birth. Children born by emergency cesarean delivery showed the highest association for metabolic disorder, while children born by spontaneous vaginal birth had fewer short and longer-term health problems, compared with those born after birth interventions (Peters et al., 2019).

We suggest those looking to reduce unnecessary intervention could consider results of systematic reviews that show relationship-based interventions, such as continuous support in labor, or continuity of midwifery care, are associated with decreased interventions, improved rates of physiological birth, and higher levels of maternal reports of wellbeing.

The QNMU envisages HWQ will be well placed to introduce preventive and restorative strategies to ameliorate the effects of these impacts and highlight where research is needed to improve the health of future generations.

Workforce Health and Wellbeing

In 2017, the *Best Practice Review of Workplace Health and Safety Queensland* identified the health care and social assistance industry sector as a priority industry (Lyons, 2017). Nurses and midwives not only provide care, but their own health and wellbeing is increasingly subject to psychosocial hazards.

Psychosocial hazards or factors are anything in the design or management of work that increases the risk of work-related stress. A stress response is the physical, mental and emotional reactions that occur when a worker perceives the demands of their work exceed their ability or resources to cope. Work-related stress if prolonged and/or severe can cause both psychological and physical injury (Safework Australia, 2019).

Common psychosocial hazards and factors affecting nurses and midwives include:

Sustained high physical, mental and or emotional effort such as:

- long work-hours;
- high workload;s
- significant time pressure;
- long periods of vigilance;
- emotional effort in responding to distressing situations or distressed or aggressive clients;
- exposure to traumatic events or work-related violence;
- shift work leading to higher risk of fatigue;
- frequently working in unpleasant or hazardous conditions (like extreme temperatures or noise, around hazardous chemicals or dangerous equipment;
- having to perform demanding work while wearing uncomfortable protective clothing or equipment (SafeWork Australia, 2019, p. 10).

Work-related psychological injury is expensive – it is estimated poor psychological health and safety costs Australian organisations $6 billion per annum in lost productivity (SafeWork Australia, 2019). SafeWork (2019, p.6) recommends employers should intervene early to identify and manage any risks and support workers showing early signs of work-related stress.

In nursing and midwifery, there is a significant body of research which explores the elements associated with a hostile work environment – moral distress, failure of advocacy, bullying and burnout.

Since 2001, the QNMU has conducted a longitudinal study of the nursing and midwifery workforce in Queensland. Nurses and midwives have continually raised concerns about the effects of the working environment on their physical and mental health. They described the emotional toll that high workloads and poor skill mix has on their mental health and the particular issues involved caring for obese patients and those who have multi-morbidities.

The prevalent outcomes across sectors related to workloads, workplace violence and supportive factors external to the workplace. The salient issues around workloads were an arbitrary skill mix, management of workloads and for the aged care sectors, in particular, poor staffing ratios.

Dominant perceptions among nurses and midwives were that workplace violence was rarely acted on, had become normalised and there was insufficient time to process incidents. Non-reporting of workplace violence was associated with repercussions (“I become the problem”) and perceptions of management instigated bullying. Family and friends,

supportive colleagues and cohesive workplaces were factors important in managing the work environment. Life outside work, in all its dimensions, was a critical counter to workplace stress (Eley et al., 2016).

Nurses and midwives need a practice environment that promotes psychological safety. Perry, et al. (2017) suggest managers and decision-makers should implement health promotion strategies for nurses and midwives, aiming to improve mental health, specifically to improve workforce retention.

The QNMU recommends HWQ consult with the nursing and midwifery workforce and its representative to identify hazards and risks, giving workers a reasonable opportunity to express their views, raise issues, contribute to the decision-making process, and taking those views into account.

Offender Health

Due to the inadequacies of prison health funding, many offenders return to their communities with blood borne viruses, chronic illnesses, addictions, etc, not only creating a risk, but also a burden on the public health and primary health systems.

Given the new Clinical Excellence Queensland initiative for the Office for Prisoner Health and Wellbeing, the QNMU recommends the relationship between this new office and HWQ be clearly articulated given prisoner health is also a public health issue.

Conclusion

The work of HWQ will enable the government to address long-term preventative health issues such as chronic disease caused by obesity. Its program should not be a series of isolated initiatives but rather an integrated, whole-of-government approach to health and wellbeing. Together they offer an opportunity to make the whole system more capable, modern, efficient and appropriate for the 21st century.

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Our more than 57,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

Our submission comments on the Bill and the role of the Health Futures Commission (the Commission) in addressing the social determinants of health that may affect wellbeing.

Healthy Futures Commission Bill 2017

In 2016, the QNMU made a detailed submission to the (then) Health and Ambulance Services Committee in which we signalled our support for the establishment of a Queensland Health Promotion Commission. In our view, this is a timely initiative given the federal government's decision to reduce health funding to the states from 2017/8 and the previous state government's withdrawal from primary health services such as school based nursing and sexual health programs.

Whilst we support the establishment of the Commission our submission draws attention to a number of questions around governance and accountability that arise from specific sections of the Bill and the Explanatory Notes (Queensland Parliament, 2017).

We have outlined our comments and questions in the following table:

Structure and format	Characteristics of the Commission	Questions
Legal form	The Commission is an "independent statutory body" established under legislation (Explanatory Notes, p.4). There will be "a level of separation from a single ministerial portfolio" (Explanatory Notes, p.7). A public service office to be established and the CEO is the head of this office (Explanatory Notes, p.6). Whole of government legislation will be applied.	What is the degree of independence expected to be exercised by the body? Will the CEO report directly to the Board?
Governance structure and relationship to minister	Multi member board (appointed by the GIC) leads a Commission which reports directly to the Minister (clause 13 of the Bill. There is a high degree of Ministerial control over strategic directions. The Commission, through the board, is subject to directions of the Minister (clauses 10 and 11 of the Bill). Annual project funding plan is approved by the Minister (projects, grants, partnerships and other arrangements) (clause 42 of the Bill). Subject to independent review five years from commencement (clause 56 of the Bill).	Will the governance arrangements result in the Commission being subject to a high level of direction regarding the compliance of the Commission's work program with government policies and strategies? Can the Minister determine the scope of the projects, grants, partnerships and other arrangements? What is the role of the Department of Health (DoH)? Does it advise the Minister on the performance of the entity and any emerging risks? What is the relationship between the Commission and the portfolio department?

		Will the DoH liaise between the Commission and the central agencies?
Financial arrangements	55% of total budget is allocated to the provision of grants (clause 41(4) of the Bill).	Who provides the Commission with a Budget? Who provides financial and other corporate support to the Commission? What is the extent of the CEO's control of the budget? Will annual reports give specific details of where the budget for grants has been allocated? Will the Commission be subject to the provisions of the Financial Accountability Handbook (the handbook)? The objective of Volume 6 of the handbook is to achieve a whole-of-government approach to grant program development and administration while maintaining some flexibility to suit an individual agency's specific grant program requirements. The *Financial and Performance Management Standard 2009* requires agencies to have regard to the Handbook when establishing their internal control systems and processes,

		and agencies must comply with the contents of the Handbook when they apply to agency circumstances.
Employment arrangements	The Commission will comprise a six-member board, a chief executive officer and up to 15 staff members (clauses 16 and 31 of the Bill and p. 5 of Explanatory Notes). The board in consultation with the Minister appoints a Chief Executive Officer who is an employee of the Commission (clause 31 of the Bill). The Commission will have "flexibility for resourcing, including attraction and retention of quality staff" (Explanatory Notes, p.7).	Will the Commission be the employer for all staff? Who will administer the Human Resources function? Why is employment capped at 15 staff?

We recognise some of these matters may not require amendments to the Bill, however, we ask the Committee to consider their importance to effective governance and risk management processes.

The QNMU supports passage of the Bill through the parliament, however, we recommend

- The Committee provides clarification on the governance matters raised in this submission (see above table).

One of the advantages of establishing the Commission will be its ability to act as an independent champion that will communicate with diverse sectors and foster innovative thinking (Queensland Parliament, 2017, p.3). In our view, the Commission will be well placed to consider the significant potential of the nursing and midwifery workforce in supporting healthy lifestyles and reducing health inequity for children and families. This will involve introducing measures that enable nurses and midwives to work to their full scope and the removal of restrictive practices that currently limit consumer access to high quality nursing and midwifery models of care.

We recognise a multifaceted approach will be necessary to achieve this goal including legislative frameworks, administrative practices, funding models, policy agendas and organisational custom and practice. However, we take this opportunity to provide the Committee with some information on nursing and midwifery that may assist in defining the nature of the Commission's work.

Whole-of-government, collaboration and systems approaches for improving and sustaining health and wellbeing.

Primary care is the foundation of our health care system. But increasingly for patients, doctors, nurses, midwives, allied health practitioners and indeed taxpayers this foundation is under stress. This is due in part to the contested nature of funding arrangements and responsibilities between the States and the Commonwealth government. One of the aims of the Bill is to strengthen linkages across sectors involved in preventive health, promote better alignment between federal, state and local jurisdictions and increase shared responsibility across the sectors (Queensland Parliament, 2017, p.30). This correlation will be an important influence in determining the scope of the Commission's functions.

We note the federal government has recently abandoned the development of a federation white paper that aimed to improve the commonwealth's financial relations with the states. This represents the loss of more than $5 million spent largely on staff costs and breaks a 2013 election promise. According to the Department of Prime Minister and Cabinet (2017), following discussions at the Council of Australian Governments (COAG) meeting on 1 April 2016, reform of federation will be progressed by the Council on Federal Financial Relations, and Commonwealth, State and Territory Treasuries.

As the Commission's focus is on primary health care, we see an important role will be to build a collaborative relationship with the Commonwealth as well as specialist community-based organisations such as the Heart Foundation, Diabetes Australia and the Kidney foundation and professional bodies representing clinicians.

In our view it is essential the Commission operates independently from Queensland Health and has a broad focus beyond the traditional health portfolio area. The Bill specifically recognises the groups of persons experiencing health inequity including Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, regional and remote communities and other communities affected by socioeconomic disadvantage.

In Queensland, the most serious gaps in the primary health system exist for patients requiring highly specialised and diverse health care such as patients experiencing mental

illness, particularly in the category of child and youth, disability and domestic violence. Service gaps in primary health care are more prominent in indigenous communities as demonstrated by the limited progress against the child mortality and life expectancy targets reported within the *Closing the Gap Prime Ministers' Report 2017* (Australian Government, 2017). According to the report:

> The target to halve the gap in child mortality by 2018 was not met in 2016. The 2015 Indigenous child mortality rate is just outside the range for the target. Over the longer-term (1998 to 2015), the Indigenous child mortality rate declined by 33 per cent. The child mortality gap narrowed (by 31 per cent) over the same period. Continued improvements in key factors which influence the health of Indigenous children, such as access to antenatal care and rates of smoking during pregnancy, have the potential to support the achievement of this target by 2018.

The target to close the gap in life expectancy by 2031 has not been met either based on data since the 2006 baseline.

> Over the longer term, the total Indigenous mortality rate declined by 15 per cent between 1998 and 2015, with the largest decline from circulatory disease (the leading cause of Indigenous deaths). However, the Indigenous mortality rate from cancer (the second leading cause of death) is rising and the gap is widening (Australian Government, 2017).

Access to appropriate primary health services for culturally and linguistically diverse communities and refugee communities remains an issue as does the ability to sustain the presence of primary health in regional, rural and remote areas.

The reasons for service gaps in the primary health care system include but are not limited to:

- Lack of health service integration;
- Limited patient coordination;
- Inability for clinicians to work to full scope;
- Limited access to the Medical Benefits Scheme (MBS) for nurses/midwives;
- Inadequate health workforce planning;
- Ineffective health policy/strategic direction;
- Insufficient funding/prioritisation;
- Minimal evaluation and public reporting;
- Geographical location.

Section 9(4) of the Bill acknowledges the 'social determinants of health' - broad social, economic and physical factors that largely shape the health and wellbeing of the population.

Most of these are outside the control of the health system. Housing, transport, education and the environment can all affect health and wellbeing. Policies that adopt a shared goal to improve health and wellbeing need to integrate responses that cross all sectors of government and portfolio boundaries.

The QMNU recommends the Commission

- engages with the nursing and midwifery workforce, its representatives, employers, community groups and the Queensland public as a first step in developing strategies for grant allocations that promote health and wellbeing through preventative measures.

Nursing and midwifery in Primary Health Care

As the largest clinical workforce, nurses and midwives play a major role in leading and driving patient-centred improvements across the health system. Nurses and midwives are appropriately regulated, educated and competent to lead and participate in the delivery of primary health care and are known to be proficient in providing holistic health services that directly meets the core principles of primary health care including:

- Patient/family/carer advocacy;
- Individual process of care;
- Educating, enabling and supporting self-management;
- Leading and coordinating multidisciplinary care;
- Leading and participating in quality improvement.

The QNMU considers there are significant opportunities for reform in the nursing and midwifery health workforce that will assist the Commission in its primary health care goals. This will involve the development and operationalisation of strategies that enable nurses and midwives to:

- work to their full scope of practice across all settings;
- expand the delivery of nursing and midwifery across the healthcare system to increase service capacity and consumer choice;
- increase nursing and midwifery services to improve the effectiveness and efficiency of the healthcare system;
- provide high-performing nursing and midwifery services through continual learning and evidence-based practice; and

- enhance patient/consumer care through access to appropriately designed data sets and information systems (Queensland Health, 2013; Altman et al., 2016; Institute of Medicine of the National Academies, 2010; Coalition of National Nursing and Midwifery Organisations, 2017; Fairman et al., 2011).

A fundamental reform priority is to expand the public/private service provider frameworks and funding models to include registered nurses and midwives, particularly in the areas of Pharmaceutical Benefits Scheme (PBS), Medical Benefits Schedule (MBS) and private insurance schemes. The inclusion of registered nurses and midwives in public/private service provider frameworks will increase the capacity of healthcare services to meet consumer demand by reducing the preferential financial support for medical models of practice over nursing and midwifery models of care.

At present, in the majority of healthcare interactions a medical officer must be appointed as the primary healthcare provider if healthcare organisations want to be fully funded for services provided, or if consumers want to obtain full rebates for services received.

The inequitable access to public/private service provider frameworks and funding models has produced perverse financial incentives, which have driven the majority of Australian healthcare services and consumers to only consider medical officers as primary healthcare providers. This bias towards medical officers has resulted in registered nurses and midwives being underutilised in the healthcare system even though evidence indicates they are capable of providing the same, if not better, outcomes for consumers than their medical colleagues (Queensland Health, 2013; Middleton, et al., 2011; Pearce et al., 2010; Sandall et al., 2016; Wilson et al., 2012; Yates & Aranda, 2013).

An inclusive service provider framework and funding model is possible through the Council of Australian Governments (COAG) 'improving access to primary care in rural and remote areas Section 19(2) exemption initiative'. This initiative provides for exemptions under section 19(2) of the *Health Insurance Act 1973* to allow eligible sites to claim against the MBS for non-admitted, non-referred professional services, which includes nursing and midwifery services provided in emergency departments and outpatient clinic settings (Queensland Health, 2013). The initiative originated from the need for public hospitals to provide primary health services to rural and remote towns due to the lack of private General Practitioner services (Queensland Health, 2013).

There are many QNMU members working in Queensland Health services that apply the section 19(2) exemption. Queensland has 32 exempt hospitals making it the state with the highest number of exemptions in Australia (Queensland Health, 2013). It is obvious, as the largest clinical workforce, that nurses and midwives are providing significant levels of primary health services to rural and remote Queenslanders (Cliffe & Malone, 2014). These

services are considered safe and of high quality. We therefore question why registered nurses and midwives are not included in the general MBS and PBS servicing framework in the first place?

The table below provide a summary of the projected key benefits that would be produced if nurses and midwives were included more in public/private service provider frameworks and funding models.

Figure 1: The impact of inclusive service provider frameworks and funding models

Healthcare system stressors (Queensland Health, 2013)	**Benefits of including nurses/midwives in service provider models (Altman et al., 2016)**
Increasing consumer demand	• increase in availability of primary healthcare providers • improvements in the capacity of healthcare services to meet demand
Increasing consumer expectations	• increase in consumer choice • decrease in wait times
Increasing burden of chronic disease	• increase in consumer access to appropriately skilled healthcare providers • increase in the capacity of health promotion and prevention services
Achieving equitable health outcomes	• increase in access to healthcare providers in rural & remote communities • increase capacity to meet the healthcare needs of Aboriginal & Torres Strait Islanders
Developing a productive health workforce	• increase in the productivity of healthcare services • increase in the integration of healthcare services
Utilising data and evidence to drive value	• provision of evidence-based contemporary healthcare services • increase in the effectiveness and efficiency of healthcare services

The QNMU believes the development of appropriate nursing and midwifery data sets at the national level will facilitate positive reform for nurses and midwives across the legislative, administrative, funding, policy and custom and practice frameworks. Minimum nursing/midwifery data sets collect specific information about the structure, process and quality outcomes of nursing and midwifery care (Montalvo, 2007; Sermeus et al., 2005). They are often used to demonstrate how nurses and midwives add value in the healthcare system (Montalvo, 2007; Sermeus et al., 2005).

In Australia, healthcare performance data sets are predominately aligned to meet the reporting requirements of generic macro-level funding models (Klynveld, Peat, Marwick, Goerdeler, 2017). The generic nature of these data sets is problematic, as the data produced does not adequately represent the contribution of nurses and midwives as the largest clinical workforce (Burston, et al., 2014).

The QNMU considers the development of specifically designed data sets and information systems should be a major reform priority for the nursing and midwifery health workforce (Queensland Nurses' Union, 2015).

Recommendation
The QNMU recommends the Commission works with the Commonwealth to expand the public/private service provider frameworks and funding models to include nurses and midwives.

Case Studies

The case studies below provide practical reflections of why the health workforce reform agenda is so important to nurses and midwives working in Queensland. The examples are indicative of the restrictive environment being experienced by nurses and midwives on a daily basis.

Again we ask the Commission to consider the potential contribution of nurses working in rural and remote areas and midwives.

Rural and Isolated Practice Endorsed Registered Nurse (RIPERN)

A RIPERN is a registered nurse who has met the Nursing and Midwifery Board of Australia (NMBA) registration standard for endorsement for scheduled medicines – rural and isolated practice (Sermeus et al., 2005). RIPERNs may practise in isolation or in collaboration with other health professionals in areas such as rural and remote hospitals, remote area emergency sites, mining sites, indigenous communities, tourist resorts, and remote pastoral stations. Predominately, RIPERNs work in locations where onsite access to medical practitioners and/or nurse practitioners is by visit only or not available at all.

The RIPERN endorsement, as per Section 94 of the *Health Practitioner Regulation National Law Act 2009* (the National Law) qualifies a RIPERN to obtain, supply and administer limited schedule 2, 3, 4 or 8 medicines appropriate to their scope of practice. This is to the extent necessary to practise nursing in a particular area and within the confines of a Chief Health Officer standing order or health services permit that must be compliant with relevant State

and Territory legislation (Sermeus et al., 2005). The services provided by RIPERNs meet the eligibility criteria for the MBS and the PBS.

In Australia, there are approximately 1,100 RIPERNs endorsed to provide emergency and primary healthcare to an advanced and/or expanded clinical scope of practice to patients in rural and remote areas (Klynveld, Peat, Marwick, Goerdeler, 2017). Queensland has the largest number of RIPERNs with 836 found on the register (Klynveld, Peat, Marwick, Goerdeler, 2017). In 2016, the NMBA proposed the discontinuation of the Registration standard: Endorsement scheduled medicines (rural and remote practice). The outcome of NMBA's proposal is still pending; however, the QNMU strongly opposes the discontinuation of this endorsement, as it places Queensland's rural and remote primary healthcare services at risk of not being able to meet the health demands of their communities.

RIPERNs contribute to public safety and provide evidence-based quality care for people living and working in rural and remote communities across Queensland (Currie, et al., 2016). The withdrawal of this endorsement would significantly reduce the numbers of staff available to supply medicines in these vulnerable locations. An alternative solution to the loss of RIPERNs is transition to nurse practitioner positions.

Nurse practitioners have access to MBS and PBS and are capable of providing high levels of clinically focused autonomous nursing care in a variety of contexts in response to varying patient/community complexities (Burston, et al., 2014). The contribution of nurse practitioners to the healthcare system is extensive and well proven (Middleton et al., 2013). However, workforce mapping in Queensland has demonstrated there are insufficient numbers of nurse practitioners to replace the RIPERN positions presently employed. This is due to the lengthy time it takes for nurse practitioners to become educationally prepared and competent for practice.

To support the sustainability, continuity and quality of healthcare in rural and remote communities, the QNMU believes the following fundamentals are necessary:

- the existence of an NMBA endorsed program of study that enables registered nurses and midwives to be educationally prepared and competent to supply medicines to consumers under the PBS, as well as, request diagnostic tests under the MBS;
- the list of rural and remote hospitals eligible for the Section 19(2) exemption requires expansion to align with growing demands within regional, rural and remote communities; and
- the development of a national health professionals prescribing pathway inclusive of core prescribing competencies for registered nurses.

Midwifery

In July 2016, the QNMU surveyed midwifery members about their work (Queensland Nurses' Union, 2016). The survey results indicated that over 50% of 'eligible' midwives[1] were not working to full scope of practice as restrictive models of care did not allow them access Medicare or use of their prescribing endorsement.

In January 2017, the standard for 'eligible' midwives was altered to create a one-step process requiring all midwives who seek a Medicare provider number to obtain an endorsement for scheduled medicines (Nurses and Midwifery Board Australia, 2017). The 130 midwives who were notated as 'eligible' are now required to join the 278 midwives who have an 'endorsement for scheduled medicines' (Nursing and Midwifery Board Australia, 2017). This transition must occur within 18 months or the 'eligible' midwives will lose their ability to access a Medicare provider number. However, the motivation for 'eligible' midwives to undertake coursework to become 'endorsed' is low as the vast majority of these midwives are employed within state healthcare services where they are unable to use their endorsement due to restrictive models of maternity care.

The mechanism to enable use of the MBS by midwives exists using the Section 19(2) exemption pathway model as outlined above for nurses. If applied more broadly, the exemption pathway would allow midwives providing primary maternity care to increase the funding prospects for healthcare services through 'own source' revenue models. 'Own source' revenue models for midwifery services have been recognised by a number of national maternity care reviews as a viable funding option for health services.

The QNMU considers the failure of the healthcare system to utilise midwives to their full scope of practice is limiting consumer access to evidence-based maternity models of care, which is a problem critically in need of reform.

The QNMU recommends the Commission works with the Commonwealth to determine reform priorities specific to regional, rural and remote communities, including:

- increasing access to the MBS and the PBS for nurses and midwives;
- expanding the list of hospitals eligible for the Section 19(2) exemption; and
- developing a national health professional prescribing pathway inclusive of registered nurses.

[1] Notation as an eligible midwife applies to a class of registered midwives and not to all registered midwives. Having notation as an eligible midwife on the register of midwives indicates that the midwife is competent to: provide pregnancy, labour, birth and postnatal care to women and their infants; and is qualified to provide the associated services and order diagnostic investigations appropriate to the eligible midwife's scope of practice. An eligible midwife may also prescribe scheduled medicines in accordance with relevant state or territory legislation once an endorsement for scheduled medicines under section 94 has been attained (Nursing and Midwifery Board Australia, 2017).

Conclusion

The work of the Commission will enable the government to address long-term preventative health issues such as chronic disease caused by obesity. Its program should not be a series of isolated initiatives but rather an integrated, whole-of-government approach to health and wellbeing. Together they offer an opportunity to make the whole system more capable, modern, efficient and appropriate for the 21st century.

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THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to the Health and Ambulance Services Committee

Inquiry into the establishment of A Queensland Health Promotion Commission

November, 2015

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Contents **Page**

Introduction

The Queensland Nurses' Union (QNU) thanks the Health and Ambulance Services Committee (the Committee) for the opportunity to make a submission to the establishment of a Queensland Health Promotion Commission.

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 53,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

The potential role, scope and strategic directions of a Queensland Health Promotion Commission

The QNU supports the establishment of a Queensland Health Promotion Commission (the Commission) signalled in the 2015/6 state budget as one of a number of preventative health measures. This is a timely initiative given the federal government's decision to reduce health funding to the states from 2017/8 and the previous state government's withdrawal from primary health services such as school based nursing and sexual health programs.

Primary care is the foundation of our health care system. But increasingly for patients, doctors, nurses, midwives, allied health practitioners and indeed taxpayers this foundation is under stress. This is due in part to the contested nature of funding arrangements and responsibilities between the states and the Commonwealth government. This correlation will be an important influence in determining the scope of the Commission's functions.

Broad social, economic and physical factors – known as the social determinants of health – largely shape the health and wellbeing of the population. Most of these are outside the control of the health system. Housing, transport, education and the environment can all affect health and wellbeing. Policies that adopt a shared goal to improve health and wellbeing need to integrate responses that cross all sectors of government and portfolio boundaries.

In our view it is essential the Commission operates independently from Queensland Health and has a broad focus beyond the traditional health portfolio area. Its sphere of activity should explore the key social determinants of health and recommend innovative strategies for improvement.

We note the *Federation White Paper* currently under development will consider principles and criteria for allocating roles and responsibilities between different levels of government. The practical application of these roles will include health, education, housing, transport, infrastructure, Indigenous affairs, justice, disability, welfare service, family and parental support, disaster recovery, environmental regulation and other areas (Australian Government, 2015). This will be an opportunity to consider the interrelationship between these policy areas and health outcomes as well as the ongoing debates around health funding arrangements that currently characterise state/federal relations.

The federal health minister (Ley, 2015) recently outlined several initiatives to 'rebuild' primary care. This involves:

- providing a 'healthier' Medicare package;
- relaunching and re-imagining digital health;
- delivering better mental health services; and
- integrating sport into the portfolio as a way towards living a longer, healthier and productive life without avoidable medical intervention.

In order to support this internal government policy work, the Minister has established:

- a Primary Health Care Advisory Group to review new and existing funding models to ensure the primary health system best supports the ongoing needs of patients, particularly those with chronic illness;
- a Mental Health Expert Reference Group providing advice to Government on how best to implement the broad ranging recommendations of the National Mental Health Commission's Review;
- an Aged Care Sector Committee that is due to report by the end of the year on a roadmap for the next wave of aged care reforms.

If, as the Minister claims, these reviews are 'integrated, considered policy work, not rash budgetary measures in isolation of each other' (Ley, 2015, p. 5), then we welcome a state based Commission that could work with the Commonwealth to promote primary health through a whole-of-government arrangement.

A Canadian review (Hutchison, Levesque, Strumpf & Coyle, 2011) outlined a number of key findings in relation to the characteristics of an optimal primary health care environment:

- Interprofessional primary health care teams;
- Group practices and networks;
- Patient enrolment with a primary care provider;
- Financial incentives and blended-payment schemes;
- Development of primary health care governance mechanisms;

- Expansion of the primary health care provider pool (e.g. nurses and midwives);
- Implementation of electronic medical records;
- Quality improvement technology, training and support.

In Queensland, the most serious gaps in the primary health system exist for patients requiring highly specialised and diverse health care such as patients experiencing mental illness, particularly in the category of child and youth, disability and domestic violence.

Service gaps in primary health care are more prominent in indigenous communities as demonstrated by the limited progress against the life expectancy target reported within the *Closing the Gap Prime Ministers' Report 2015* (Australian Government, 2015).

Access to appropriate primary health services for culturally and linguistic diverse communities and refugee communities remains an issue as does the ability to sustain the presence of primary health in regional, rural and remote areas.

The reasons for service gaps in the primary health care system include but are not limited to:

- Lack of health service integration;
- Limited patient coordination;
- Inability for clinicians to work to full scope;
- Limited access to the Medical Benefits Scheme (MBS) for nurses/midwives;
- Inadequate health workforce planning;
- Ineffective health policy/strategic direction;
- Insufficient funding/prioritisation;
- Minimal evaluation and public reporting;
- Geographical location.

The QNU recommends the Commission

- is independent of Queensland Health and has a broad remit to consider the social determinants of health extending beyond a narrow health policy framework;
- develops clear understandings of its role in primary health particularly given the ongoing debates around commonwealth/state funding;
- liaises with the federal government on matters the federal Minister identified as requiring integrated policy work – primary care, mental health and aged care;
- considers ways to measure and evaluate progress in closing the service gaps in primary health care through more effective workforce planning, public education programs and whole-of-government policy initiatives.

The effectiveness of collaborative, whole-of-government, and systems approaches for improving and sustaining health and wellbeing, including models used in other jurisdictions (including specific agencies or whole-of-government policy frameworks).

In recognition of the need for joint action where the most important determinants of health are found in sectors other than health, the World Health Organisation (WHO) (2011) promotes 'smart' governance through new independent agencies and expert bodies that combine whole-of-government with whole-of-society approaches. The QNU believes the proposals identified by the WHO could guide the role, scope and strategic direction of the Commission. These include governing through:

- collaboration;
- community engagement;
- a mix of regulation and persuasion;
- independent agencies, adaptive policies;
- resilient structures and foresight.

Independent expert bodies such as agencies, commissions, regulators and auditors are playing increasingly vital roles in providing evidence, maintaining ethical boundaries, extending accountability and strengthening democratic governance in health (World Health Organization, 2011). The Commission could encompass these roles as well as providing quality control and health impact assessments.

The importance of these functions increases with the move towards a knowledge society with rapid innovation. Health promotion must include objective and subjective measures to capture progress and enable public scrutiny. Given the long-term nature of many health conditions, anticipatory governance also requires new forecasting methods. A wide variety of smaller-scale interventions at local and community levels such as school based youth health nurses can increase social resilience and address more fundamental systemic challenges.

To that end, the Commission could consider the *Health in All Policies* approach of the South Australian Government. In South Australia, a whole-of-government framework - South Australia's Strategic Plan - seeks to enhance the state's prosperity, sustainability and quality of life for its citizens, and has been described as a blueprint for action on the social determinants of health (Kickbusch, 2007). Many of the targets contained in South Australia's Strategic Plan are important social determinants of health. Action on the targets aims to produce positive health and wellbeing outcomes for the population, and contribute to longer term reduction in health care expenditure. The plan recognises the need for concerted and cooperative action across multiple sectors of South Australian society to achieve the targets (Government of South Australia, 2015).

The South Australian Government's implementation of *Health in All Policies* was a significant development in the applied use of research evidence on determinants of health, and a first for Australia. This initiative was based on 10 underlying principles that reflect health as a shared goal across government. In particular, it:

- recognises health is a human right;
- acknowledges health is an outcome of a wide range of factors that require a shared responsibility and an integrated policy response;
- acknowledges that all government policies can have positive and negative impacts on the determinants of health;
- recognises that the impacts of health determinants are not equally distributed among population groups;
- recognises that health is central to achieving the State's strategic plan;
- acknowledges that efforts to improve health will require sustainable mechanisms that support government agencies to collaborate in developing integrated solutions;
- acknowledges that many of the most pressing health problems require long term policy and budgetary commitment;
- recognises that indicators of success will require monitoring and reporting;
- recognises the need to consult regularly with the public;
- recognises the potential of partnerships for policy implementation between levels of government, science, academia, business, professional organisations and non-governmental organisations (Government of South Australia, 2013) .

The success of the initiative has rested on a number of key drivers including:

- partnering with government departments on their policy imperatives to support the development of healthy public policy;
- high-level mandate from central government;
- leveraging from existing government decision making structures;
- jointly generating evidence based solutions with project partners;
- integrating qualitative and quantitative social science methodologies to identify solutions for complex, "wicked" policy issues (Government of South Australia, 2013).

The *Health in All Policies* initiative demonstrates its value as an approach to collaborative policy development. *Health in All Policies* also provides a framework for meeting the needs of sectors outside of health as well as long term population health and wellbeing goals. This reflects the idea of reciprocity, one of the key philosophies underpinning the initiative. Cross-sector collaboration and partnerships have been recognised as important system building strategies. Mechanisms to support and systematise these practices across state and local government help to ensure ongoing action to address the social determinants of health and improve the population's health and wellbeing (Government of South Australia, 2013).

The QNU recommends the Commission

- considers the *Health in All Policies* initiative of the government of South Australia as a whole-of-government approach to health policy development.

Emerging approaches and strategies that show significant potential

The 'health and wealth' agenda is based on the scientific evidence that health is an investment, not just an expenditure. Healthier populations are more productive, participate more actively in the labour market and gain higher incomes (McDaid, Drummond & Suhrcke, 2008; Suhrcke, Lorenzo & McKee, 2007; Suhrcke, McKee, Sauto Arce, Tsolova & Mortenson, 2005).

Recent European examples of a whole-of-government approach for health in all policies are found in England, Finland, France, the Netherlands, Norway and Sweden. These countries use combinations of governance tools such as policy formulation, target setting, public health laws, cabinet level coordination, interdepartmental committees, horizontal and vertical coordination mechanisms, public hearings, cross-department spending reviews within a relatively coherent government framework (Wismar & Ernst, 2010). They use these tools to reach out to other government departments and sectors to integrate health in other policies.

A recent OECD report (2015) found:

- Australia's health system is highly fragmented, making it difficult for patients to navigate. Devolving primary care to the states and territories would better align health services, increase efficiency, and reduce the disruption to continuity of patient care;
- The development of ten national standards for mandatory hospital accreditation represents an important element of the safety and quality improvement architecture of Australia's health system. Expanding the scope of the standards to take in aged care, mental health services and primary health care should be a priority.

Some aspects of the primary health care system are working well or the concept has the potential to work well for people with chronic/complex health conditions. These include:

- Access to chronic disease management plans, led by primary health care providers with access to integrated health care teams delivering primary, secondary and tertiary services across all health care sectors allowing holistic patient assessment, care planning, implementation of treatment and evaluation of health outcomes;

- In areas where primary health services are limited or do not exist (e.g. rural and remote communities) established state and local government health services and resources are used to fill the service gap;
- The introduction of Medicare Locals delivered some improvements in filling service gaps, coordinating care and rebuilding links between community services and hospitals within certain areas of Queensland's primary health care system. The success of this concept was mainly limited to geographical locations where high patient demand prompted 'buy in' from health service providers;
- Specialty community-based organisations such as the Heart Foundation, Diabetes Australia and the Kidney foundation advocate, establish and support networks between patients and providers spanning primary, secondary and tertiary services across all health sectors. These organisations contribute significantly to health care research.

As the largest clinical workforce, nurses and midwives play a significant role in leading and driving patient-centred improvements across the health system. Nurses and midwives are appropriately regulated, educated and competent to lead and participate in the delivery of primary health care and are known to be proficient in providing holistic health services that directly meets the core principles of primary health care including:

- Patient/family/carer advocacy;
- Individual process of care;
- Educating, enabling and supporting self-management;
- Leading and coordinating multidisciplinary care;
- Leading and participating in quality improvement.

In Queensland, there are several nurse-led chronic disease services working in collaboration with multi-disciplinary team members to provide effective and efficient chronic or complex care within Hospital and Health Services. These services have produced a variety of positive outcomes for patients, communities and health services.

The introduction of Nurse Navigator positions will be a positive means of addressing the current difficulties in accessing and traversing the health system. This is just one practical method of giving people more information and ultimately better care.

The QNU recommends the Commission

- engages with the health workforce, their representatives, employers, community groups and the Queensland public as a first step in developing strategies promoting health and wellbeing through preventative measures.

Conclusion

The work of the Commission will enable the government to address long-term preventative health issues such as chronic disease caused by obesity. Its program should not be a series of isolated initiatives but rather an integrated, whole-of-government approach to health and wellbeing. Together they offer an opportunity to make the whole system more capable, modern, efficient and appropriate for the 21st century.

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