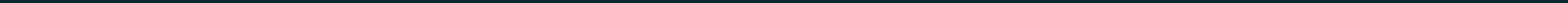
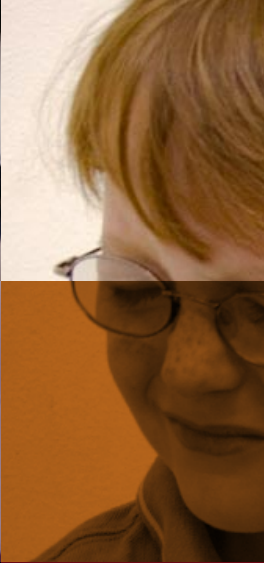


Primary Health Care in Australia

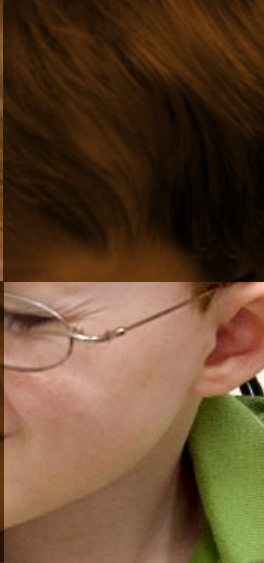
A nursing and midwifery consensus view | April 2009



ME
A
PERSON



WE PRIMARY
HEALTH
CARE
PROVIDERS



On launching the final report of the Commission of the Social Determinants of Health, a Commission established by the World Health Organisation (WHO) Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health¹, Dr Margaret Chan, the Director General of WHO said:

"Health inequity really is a matter of life and death. The Commission's main finding is straightforward. The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one... This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health... But, let me emphasize, it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place".²

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Prepared by: Amanda Adrian on behalf of the leading nursing and midwifery organisations in Australia

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Amanda Adrian & Associates

PO Box 1065 ROZELLE NSW 2039

Email: amanda@aadrianassoc.com.au

Web address: www.aadrianassoc.com.au

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April 2009

Primary health care in Australia

A nursing and midwifery consensus view

Setting the scene | The ambulance at the bottom of the cliff

Joseph Malins (1895)

'Twas a dangerous cliff, as they freely confessed,
Though to walk near its crest was so pleasant;
But over its terrible edge there had slipped
A duke and full many a peasant.
So the people said something would have to be done,
But their projects did not at all tally;
Some said, "Put a fence 'round the edge of the cliff,"
Some, "An ambulance down in the valley."

But the cry for the ambulance carried the day,
For it spread through the neighbouring city;
A fence may be useful or not, it is true,
But each heart became full of pity
For those who slipped over the dangerous cliff;
And the dwellers in highway and alley
Gave pounds and gave pence, not to put up a fence,
But an ambulance down in the valley.

"For the cliff is all right, if your careful," they said,
"And, if folks even slip and are dropping,
It isn't the slipping that hurts them so much
As the shock down below when they're stopping."
So day after day, as these mishaps occurred,
Quick forth would those rescuers sally
To pick up the victims who fell off the cliff,
With their ambulance down in the valley.

Then an old sage remarked: "It's a marvel to me
That people give far more attention
To repairing results than to stopping the cause,
When they'd much better aim at prevention.
Let us stop at its source all this mischief," cried he,
"Come, neighbours and friends, let us rally;
If the cliff we will fence, we might almost dispense
With the ambulance down in the valley."

"Oh he's a fanatic," the others rejoined,
"Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could;
No! No! We'll support them forever.
Aren't we picking up folks just as fast as they fall?
And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence,
While the ambulance works in the valley?"

But the sensible few, who are practical too,
Will not bear with such nonsense much longer;
They believe that prevention is better than cure,
And their party will soon be the stronger.
Encourage them then, with your purse, voice, and pen,
And while other philanthropists dally,
They will scorn all pretence, and put up a stout fence
On the cliff that hangs over the valley.

Better guide well the young than reclaim them when old,
For the voice of true wisdom is calling.
"To rescue the fallen is good, but 'tis best
To prevent other people from falling."
Better close up the source of temptation and crime
Than deliver from dungeon or galley;
Better put a strong fence 'round the top of the cliff
Than an ambulance down in the valley.

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Primary health care The consensus view of nurses and midwives

This consensus view outlines a vision for primary health care for people in Australia. It is a vision supported by many of the organisations representing nurses and midwives working in Australia in 2009 across all sectors of health and aged care.

It is written for the wider community; for nurses and midwives; and for others who influence health policy in Australia.

The vision sets out the values, principles and aspirations for the development of a comprehensive primary health care strategy across Australia. Many of its features are not representative of health and health care in Australia currently.

Nurses and midwives consider the current climate for health reform in Australia offers a unique opportunity to refocus our health policy and funding strategies. To do this requires a shift of emphasis from the narrow perspectives of hospital based care with its treatment and cure of already established disease; to the promotion of health, the prevention of disease and injury and the diminution of health inequities of all Australians across their lifespan.

It should be noted there are already unique and innovative exemplars of primary health care teams working with communities who are currently attempting to achieve this vision in Australia. In some instances these have been in place for a number of years. Regrettably the communities and the health professionals working in these services continue to be confronted by considerable structural impediments. These obstacles prevent them from realising their objectives; and also prevent other services from being able to emulate these national models and other successful international primary health care models.

While there will always be a need for an ambulance at the bottom of the cliff, let us at last build that fence at the top!

To achieve the nurses' and midwives' vision for primary health care in Australia it is imperative to:

- Centre health policy in Australia around primary health care for people throughout their lives - primary health care is demonstrably a person centred, holistic approach incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of accessible, essential, integrated, quality care based upon practical, scientifically sound and socially acceptable methods and technology for all in the Australian community.
- Invest in 'health' by funding health promotion and the prevention of illness and injury - focussing on the social determinants of health.
- Ensure primary health care funding is based on the demonstration of positive health outcomes - for people and communities, the promotion of teamwork and collaboration and cost effectiveness.
- Fund acute health care equitably and sustainably - but recognising acute health care is an 'effect' rather than a 'cause', and therefore it must be linked as an extension of primary health care.
- Establish respectful partnerships between communities and individuals and health care providers, managers, researchers and educators - centred on achieving and maintaining optimum health for all.

- Ensure citizens and others living in Australia participate individually and collectively in the planning and implementation of their health care in a collaborative way -
the development and implementation of health policy and primary health care services are based on the maxim 'nothing about us without us'.
- Acknowledge the skills, knowledge and experience of all health professionals, including nurses and midwives and use these in effective transdisciplinary* teams -
that enable individuals and communities to have equitable access to comprehensive primary health care services.
- Invest in transdisciplinary education and research for the health workforce -
designed to meet the health needs of the community through primary health care provision.
- Work closely with the non-health organisations and agencies responsible for services that can determine the health status of individual people and communities -
for example housing, education, agriculture, water resources and environmental management.
- Focus on the quality and safety of primary health care -
with robust governance structures and regulation of health professionals in place for that purpose.

Nurses and midwives have a strong contribution to make to the 'new' primary health care policy in Australia, particularly in the areas of:

- Health promotion, illness and injury prevention for infants, children and youth in non-traditional health settings.
- Chronic and complex care management in the community.
- Community mental health care.
- Responsive maternity, maternal, child and family health services.
- Aged care in community and residential care settings.
- Generalist frontline health care services across all settings, but particularly those currently not well served such as rural and remote communities, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, homeless people, school communities, asylum seekers and refugees, sexual health.
- Liaison services between community care and acute health care services.
- Health promotion, illness and injury prevention and continuity of care for all Australians throughout peoples' lives.

*See Glossary of Terms

The leading nursing and midwifery organisations in Australia strongly support the adoption of primary health care as the centrepiece of health policy in Australia to improve the health of all people living in Australia, across their lifespan.

Interim measures

Without diminishing the need for a more comprehensive and equitable approach to primary health care and supporting funding mechanisms, the nursing and midwifery professions recognise the inevitability of a transition phase between the system that currently exists and the system we are striving for.

During any transitional period nurses and midwives are adamant that the significant barriers to access for people to affordable, safe, high quality primary care are removed.

The professions also note the lack of, or the minority representation of community and health professional groups other than medical practitioners on key health policy committees, task forces, working groups and reform agencies. Nurses and midwives call for greater equity in parties providing advice to Government on these important reform initiatives.

To better meet the needs of the community, nurses and midwives call for:

- An acknowledgement that appropriately qualified health professionals other than medical practitioners are safe and competent to lead a transdisciplinary primary health care team.
- All persons receiving health care to obtain Medicare rebates and PBS subsidies for services provided by appropriately qualified health professionals, including nurses and midwives **in their own right**. At present, in most cases MBS funded services can only be provided 'for and on behalf of' health professionals holding provider numbers, usually medical practitioners.
- Identification of innovative means of using current funding mechanisms to reward the establishment of transdisciplinary teams in primary health care services eg incentives to be provided to existing general medical practices that pool MBS income and demonstrate the use of broader transdisciplinary primary health care teams.
- Appropriate representation of the community in the development of the national primary health care policy and funding arrangements.
- Appropriate representation of nurses and midwives in the development of the national primary health care policy and funding arrangements commensurate with the centrality and potential of their professional roles in the provision of primary health care.

Nursing and midwifery organisations supporting the primary health care consensus view

- Australasian Sexual Health and HIV Nurses Association (ASHHNA) #
- Australian Association of Maternal, Child and Family Health Nurses (AAMC & FHN)
- Australasian Cardiovascular Nursing College (ACNC)
- Australian College of Children and Young People's Nurses (ACCYPN)
- Australian College of Nurse Practitioners (ACNP) * #
- Australian College of Operating Room Nurses (ACORN) #
- Australian Diabetes Educators Association (ADEA)
- Australian Faith Community Nurses Association (AFCNA)
- Australian Nursing Federation (ANF) * #
- Australian Practice Nurses Association (APNA) * #
- Australian Women's Health Nurses Association (AWHNA) #
- Cancer Nurses Society of Australia (CNSA)
- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)
- CRANAplus - the Professional Body for Remote and Isolated Practice * #
- Geriaction #
- National Enrolled Nurse Association (NENA)
- Psychogeriatric Nurses Association Australia Inc (PGNA) #
- Royal College of Nursing Australia (RCNA) * #
- Royal District Nursing Service (RDNS) #
- The Australian College of Mental Health Nurses Inc (ACMHN) * #
- The College of Nursing
- The Council of Deans of Nursing and Midwifery (CDNM) #
- Victorian Association of Maternal and Child Health Nurses (VAMCHN)

* Primary Health Care Working Group | # Primary Health Care Project Advisory Committee

Primary health care The centrepiece of health policy in Australia

The current climate for health reform in Australia offers a unique opportunity to refocus our health policy and funding strategies. This can be achieved by shifting the emphasis from the narrow perspectives of hospital based care and the treatment and cure of already established disease to the promotion of health, the prevention of disease and injury and the diminution of health inequities for all Australians across their lifespan.

The leading nursing and midwifery organisations in Australia strongly support the adoption of primary health care as the centrepiece of health policy in Australia to improve the health of all people across their lifespan.

Primary health care is currently defined by the World Health Organisation (WHO) as:

...essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.³

This definition is almost identical to that in the Declaration of Alma-Ata of 1978.⁴

'Health' for Aboriginal and Torres Strait Islander peoples

The Aboriginal and Torres Strait Islander peoples in Australia have developed this concept further in creating their unique models of community

controlled health services and have defined 'health' for Aboriginal peoples as:

Aboriginal health is not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being.⁵

Primary health care for Aboriginal and Torres Strait Islander peoples

The National Aboriginal Community Controlled Health Organisation (NACCHO), in its submission on the Discussion Paper: *Towards A National Primary Health Care Strategy* in February 2009 has adapted the Declaration of Alma-Ata definition further and defined primary health care as:

... a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. Primary health care is an Aboriginal cultural construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems, including promotive, preventative, curative and rehabilitative services.⁵

Primary care or primary health care?

Traditionally in Australia, the emphasis has been on 'primary care' rather than 'primary health care'. General practice in Australia is founded largely on the 'primary care' model and arguably, 'primary care' is a subset of 'primary health care'. 'Primary care' has been:

...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 practised 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.⁶

While the terms have been used interchangeably, they generally represent two different philosophical approaches to health care. This in turn can disguise the transformative potential of strategies and approaches that can make the fundamental changes necessary to improve health status outside the traditional domain of health, that relate to broader social determinants of health. Secondly, the structures, funding mechanisms and practices of the primary care sector in Australia in 2009, centred as they are upon the providers (largely general medical practitioners) and the management of disease and injury are not always compatible with notions of comprehensive primary health care.⁶

Another way of viewing the differences between the primary health care that is the norm in Australia in 2009 in comparison to international models of primary health care being promoted is by seeing them as 'selective primary health care' versus 'comprehensive primary health care'. The following table highlights the differences.

Characteristic	Selective PHC	Comprehensive PHC
Main aim	Reduction of specific disease - technical focus	Improvement in overall health of the community and individuals - and health for all as overall social and political goal
Sectors involved	Strong focus on health sector - very limited involvement from other sectors	Involvement of other sectors central
Strategies	Focus on curative care, with some attention to prevention and promotion	Comprehensive strategy with curative rehabilitative, preventive and health promotion that seeks to remove root causes of disease
Planning & strategy development	External, often 'global', programmes with little tailoring to local circumstances	Local and reflecting community priorities professional 'on tap not on top'
Participation	Limited engagement, based on terms of outside experts and tending to be sporadic	Engaged participation that starts with community strengths and the community's assessment of health issues, is ongoing and aims for community control
Engagement with politics	Professional and claims to be apolitical	Acknowledges that PHC is inevitably political and engages with local political structures
Forms of evidence	Limited to assessment of disease prevention strategy based on traditional epidemiological methods, usually conducted out of context and extrapolated to situation	Complex and varied research methods including epidemiology and qualitative and participatory methods

Source: Baum F (2007) 'Health for All Now! Reviving the spirit of Alma Ata in the twenty-first century: An introduction to the Alma Ata Declaration' *Social Medicine* 2(1): 34-41.

Importantly, nurses and midwives recognise improving health through primary health care can only be achieved by placing health in its social, cultural, political, economic and environmental context. Its success comes from having the community and its citizens as drivers of the broader national policy; as well as of their own health and any care they may require as individuals. The health and wellbeing of the local community of which a person is a member is seen as a critical factor in a person being *able to reach their full potential as a human being* - the essence of the approach to primary health care promoted by Aboriginal and Torres Strait Islander peoples.⁵

While recognising that the established model of 'primary care' has served many people well in achieving improved health; nurses and midwives have a far wider ranging vision for improving the health and wellbeing of people living in Australia.

Australian nursing and midwifery organisations are explicitly supporting 'primary health care' in its broadest sense; placing health in its social, cultural, political, economic and environmental context.

The role of nurses and midwives, like other health professionals, is as providers of health promotion, prevention strategies, assessment, care, treatment, rehabilitation and palliation. While health professionals can be participants as citizens and experts in some aspects of the provision of primary health care, their contributions must be as partners, guides and collaborators. Care must be provided in a way that is not seen as dominating, with the providers imposing their values and will.

This consensus view is developed from an initiative in 2008 across a number of leading nursing organisations to reach a consensus position concerning the roles of registered

nurses and nurse practitioners working in primary health care (see Appendix A). For the purposes of this paper the roles of registered midwives, who have a long history and vital role in primary health care in many settings are included. Having a pan-professions approach to the shape and structure of the health system in Australia provides a powerful voice in the health reform debate.

This paper draws on published, peer-reviewed articles and the pertinent work currently being undertaken by the World Health Organisation (WHO) as part of the *Now More than Ever: Nurses and Midwives in Primary Health Care* project.* It also draws upon the many submissions, commissioned papers, debates and discussions that have underpinned the work of the National Health and Hospitals Reform Commission and the National Primary Health Care Strategy.

The paper includes recent interviews with and accounts of nurses and midwives currently working in primary health care in Australia in a wide range of roles.

*See endnote 1

Primary health care in action | Coachstop Caravan Park Outreach Project tackles the social determinants of health

An initiative of the Maitland Community Health Service demonstrates that a nurse led primary health care response to the detrimental aspects of a social environment can pay dividends on a community's health status. The following story exemplifies the World Health Organisation (WHO) concept of 'health equity through action on social determinants of health'.

The Coachstop Caravan Park is home to 150-200 people classified as 'at risk' families and individuals. Many park residents have been homeless, in prison and juvenile institutions, a number are from mental health facilities or refuges, and some are transient, moving from park to park in search of affordable housing.

In 2000, health professionals observed a high number of referrals from this park coming from a number of agencies including the Emergency and Obstetrics Departments of Maitland Hospital, Department of Community Services, Australian Childhood Immunisation Register and in one instance a funeral director. Follow up of park residents was complicated by factors such as their being unable to be contacted by phone, frequently not at home when health staff attempted to visit them, a general lack of trust of 'government services', and the transient lifestyle of many.

It became apparent that to achieve contact, health professionals needed a presence at the park. The Maitland/Dungog Community Health Service negotiated to run a pilot outreach child and family health clinic from an onsite van staffed by a child and family health nurse and a generalist community nurse. A picture emerged of a very disadvantaged community sharing common characteristics: largely reliant on Centrelink benefits, poor functional literacy skills, frequent domestic violence, high level of substance use, high rate of Hepatitis C, social isolation with poor

self esteem (particularly the women), poor school attendance, a high proportion of residents with a history of childhood sexual assault, abuse and/or neglect, failure to access mainstream health services (many individuals did not have a Medicare card), or general practitioners.

With funding from the NSW Health Primary Healthcare and Partnerships (Women's Health Outcomes), a two year project was initiated, with the outreach van being staffed by an early childhood nurse, a project officer (registered nurse), a registered psychiatric nurse (with a graduate diploma in clinical drug dependence and immunisation accredited). The intervention was based on the Social Health Model addressing the WHO social determinants of health. Additionally the WHO Ottawa Charter for Health Promotion 1986, was referred to, which includes advocacy and enablement as a means to achieving equity in health.

The project design combined innovative outreach with community capacity building and partnerships with a range of other service providers including drug and alcohol services, dental and women's health services, immunisation services, Centrelink, a volunteer general practitioner, education, and community businesses and charities such as the St Vincent de Paul food program.

The project's core values were:

- Residents providing the driving force for program reorientation and decision making.
- Interactions based on mutual respect and trust to give positive outcomes.
- Stakeholder decision sharing as a key feature of the delivery model.
- Sustainable inroads gained as a fundamental objective.

With these values, the objectives of the project included:

- Establishing partnerships to address the social determinates of health.
- Reorienting health services to meet the needs of park residents.
- Strengthening working partnerships between the residents and mainstream health services.
- Developing capacity building within the caravan park.
- Increasing residents literacy and health literacy through education.
- Strengthening community action. Helping residents set their health priorities and plan strategies to address them.

Six indicators of the project's success were identified as: reduce social isolation, improve housing options, increase in personal skills, literacy and health literacy, improve sense of a supportive community, improve access to appropriate health services, and increase maternal and child health outcomes.

Based on data from the Emergency Department of The Maitland Hospital, primary health care interventions were established to address underlying social and health issues. For example, after a number of presentations with needle stick injuries, disposal bins were placed in the toilets and a needle and syringe program established at the outreach van.

Another important intervention was advocacy for improved living conditions in the park. Children were frequently admitted to hospital for respiratory conditions exacerbated by damp, musty vans. Improvements in nutrition necessarily began with negotiating for full size refrigerators in all the vans, as opposed to bar fridges. Lack of transport, a barrier to accessing services, was solved by a partnership between a businessman, St Vincent De Paul and Centrelink.

In six months there was the beginning of a sense of community and change of culture in the park. Park residents began attending TAFE courses and antenatal care. Children were attending school. Further capacity building took place amongst other health services, schools and other government departments. These organisations reorientated their services to make them more accessible, many delivering from the outreach van. Outreach services were extended to paediatric clinics and a public health physician volunteered as a general practitioner on his day off. Social entrepreneurial partnerships were established with private businessmen and fundraising was used to allow children to participate in sport, dance classes, school excursions and in some instances to supplement preschool fees.

As park residents regained confidence in health and social services they were linked back into mainstream services.

The Coachstop Caravan Park Outreach Service continues to evolve and now has a permanent home (a demountable) in the park. It has been successful in engaging socially and economically disadvantaged families and individuals living in the caravan park and delivering a high quality health service on minimal funding. The intervention has been very successful in returning family members to housing, work, employment and health services. The women now attend antenatal care and the children have access to enriched childcare and preschool. Additionally, the broader community is now aware of the residents' plight and there is a subsequent break down in social isolation. The holistic approach of the intervention allowed residents to make changes in many areas of their lives. The broad range of collaborative partnerships all delivering services onsite through the outreach van made the services accessible. Ease of access is essential when peoples' lives are in chaos.

Source: Project Coordinator Loretta Baker

Primary health care in action | Health reform begins locally at Walwa Bush Nursing Centre

A small town in rural Victoria is leading the way in primary health care with a model that relies heavily on nurse led services. When the Walwa Bush Nursing Hospital closed its doors in 2002 after providing 80 years of service to the Walwa and Jingellic region of the Upper Murray in Victoria, it was succeeded by the Walwa Bush Nursing Centre (WBNC). Nurse practitioner and CEO of the WBNC, Sandi Grieve arrived in Walwa to take up a nursing position at the 10 bed Bush Nursing Hospital around 20 years ago. "I came to Walwa almost by mistake," Sandi says. "My husband and I were in the town on holiday and I happened to mention that I was a nurse and would like to work in the country. I had a call a couple of weeks later from the director of nursing at Walwa asking me when I could start."

Sandi continued working at Walwa and has witnessed many changes to the service which previously operated as a private hospital. The WBNC was created in December 2002 and has grown into an innovative primary care centre offering 24 hour, seven day emergency care; community nursing; a co-located medical centre; a community centre with a gymnasium; a rural transaction and business centre and internet café.

Sandi says the model brings great benefits to the rural community that could be replicated in metropolitan health services. "We get a lot of value out of how we manage our patient loads and how we use nursing staff in the service," she says.



"It is extremely beneficial not only for the service but for the community because they always have access to nursing care and liaison with GPs."

Highly skilled and educated nurses work to full capacity at the WBNC and ease the load for medical staff who are available to address more complex health care needs. "GPs need to be protected to an extent from casual enquiries but nurses triage all of those cases. Nurses here are advanced practice nurses and they work to maximum capacity," Sandi says. "If the GP has a full patient load on any given day and someone who is very ill calls in the morning the nurses will see the patient and do some tests and take a comprehensive history and drill that down. Nurses can expedite the process almost to the point of making a diagnosis. The GP will then consider all of that information and order a treatment plan which the nurse then carries out. Nobody is rushing and the GP is getting a good throughput without any inconvenience to the patient."

Opposition to expanded roles for nurses and nurse practitioners comes from a lack of understanding, Sandi says. "I don't think those people who are scared by the development of nursing roles understand that we are not trying to be substitute doctors. If you compare the training GPs do with nurse practitioners it does seem scary but nurse practitioners become expert in one area of practice and it seems we have trouble getting that message across."

Nurse practitioner Sandi Grieve - Victoria



The vision of nurses and midwives for primary health care in Australia

This vision outlines the values, principles and aspirations for the development of a comprehensive primary health care strategy across Australia. It contains elements that are not universal features of health and health care in Australia at the present time. It is acknowledged there are unique and innovative exemplars of primary health care teams who are attempting to achieve this vision; and in some instances have been doing so for a number of years. They continue, however, to have significant structural impediments preventing them from realising their objectives. Importantly, these impediments also prevent other services from being able to emulate the more successful international service models.

The vision of nurses and midwives in Australia is for a comprehensive primary health care strategy for Australia, encompassing these values, principles and aspirations.

HEALTH

Health is a state of complete physical, emotional, social and cultural wellbeing of the person across the period of their life, enabling them to achieve their full potential as a human being. This also applies to the physical, social, emotional and cultural wellbeing of their whole community. It is not merely the absence of disease, injury or disability.^{4,5}

THE SOCIAL DETERMINANTS OF HEALTH

It is critical to focus on the social determinants of health in the quest for health. The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one. Health care is an important

determinant of health. Lifestyles are important determinants of health and factors in the social environment determine access to health services and influence lifestyle choice in the first place. Areas for action include early life support and care, ecosystem sustainability, education, employment, food and water security, health care, housing, income, social inclusion and social welfare.²

PRIMARY HEALTH CARE

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

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

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

A variety of responsive forms of service delivery, provided by a range of providers, including nurses and midwives must be available to meet the needs

CARE COORDINATION AND TEAM BASED APPROACH TO CARE

Primary health care is based on a model of collaborative transdisciplinary care as opposed to being led by any one professional group. In a model of transdisciplinary care, managing the continuum through health promotion; prevention of illness; and illness to health involves a range of health professionals and other workers. The safety and quality for individuals and the community of any primary health promotion, prevention or intervention strategy is always an essential consideration.

The needs of the person and the local community dictate what health care professional leads the health care team; and also who is most appropriate to coordinate overlapping aspects of a person's care. For example in many Aboriginal communities Aboriginal health workers (AHWs) are often the most appropriate health professionals to lead the primary health care initiatives.⁸

Transdisciplinary care allows for appropriate use and focus of the expertise of a mix of health care professionals. Primary health care models of care go beyond multidisciplinary and inter-professional collaboration, allowing for greater access, effectiveness and efficiency of primary health care provision.⁹⁻¹¹

Ensuring continuity in assisting people in the maintenance of their health and the management of any health care, treatment or rehabilitation is a high priority in primary health care. Cross sectoral collaboration between the primary health care sector, acute and aged care sectors is critical. The primary health care team has a responsibility to ensure this continuity is achieved and managed by the most appropriate health professional(s) in a manner that inspires understanding and confidence for the person concerned; and

enables safe transition or referral to other health professionals in the team, or to other teams when necessary.

The primary health care models of care are sustained by integrated, functional and mutually supportive coordination and referral systems.⁴

Collaboration between colleagues who are clinicians in active practice, researchers, policy makers and educators enable the teams to maintain their capacity to innovate and improve practice for the benefit of the community. It is also critical to ensure that the primary health care workforce nurtures and supports new professionals and workers entering; while maintaining and developing their own skills and the skills of the team. In addition the workforce needs to assist the community and individuals to develop and maintain the knowledge, skills and capacity to manage their own health.

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

PARTICIPATION

People have the right and duty to participate individually and collectively in the planning and implementation of their health care in a collaborative way.⁴

The development and implementation of health policy and health services are based on the maxim '*nothing about us without us*'.

*See endnote 2

The legitimacy and sustainability of any 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 and midwives and other health providers and managers within the health sector to assess evidence, develop priorities and develop and implement plans to improve health and health care according to those priorities.

Strategies to achieve active community participation in the development of health policy, health services and in their own care recognise the often disempowered nature of people's relationships with health care providers in a health system that is highly complex and confusing for people. This requires support for building the capacity of persons to be actively involved in making decisions about their own health and health care.⁷

Genuine engagement of local Aboriginal and Torres Strait Islander communities is essential to maximise participation of Indigenous peoples in designing primary health care strategies that harmonise with the local communities' ways of life, including full community control where this is feasible.⁵

Community controlled health services provide a model for primary health care where power is explicitly vested in local communities. Such models should be considered where this level of local community participation has the potential to improve the health of individual people and the community as a whole, and where other models may be less successful. Other community health services such as those established by non-government organisations such as well women's services are also successful models for achieving community participation and commitment.

PARTNERSHIPS FOR HEALTH

This vision for Australia's primary health care policy empowers the community and individual health consumers to establish productive relationships for the delivery of health care. This in turn enables nurses and midwives and other health care providers to collaborate and work in partnership with people who are health consumers, and with local communities.

Nurses and midwives have an important role in helping communities and people of all ages become more self-reliant and better able to manage their own health care needs. Nurses and midwives have a responsibility to communicate clearly; to help people and communities to understand the choices available to them, to be inclusive of the views the person (including cultural demands and sensitivities); and to empower people to take an active role in illness prevention and treatment in a relationship of mutual respect.

Partnership requires recognition of shared responsibility; while acknowledging that some people may require support to do this in relation to their own health.⁷

Partnerships are also forged between the community, health providers and other services impacting on the social determinants of health in the community, that are outside traditional health services.

ACCESS AND EQUITY

Nurses and midwives recognise the diversity of people constituting Australian society, including immigrants, asylum seekers, refugees, and detainees; and the responsibility of nurses and midwives to provide just, compassionate, culturally competent, and culturally respectful and responsive care to each and every person requiring or receiving care.^{12,13}

Therefore comprehensive accessible and universal health care services must be available to all in the Australian community, with effective primary health care forming the foundation of the system. These services are funded by one universal funding system, with funds generated through the national taxation system. Health care is available on the basis of need, not the ability to pay, regardless of: socio-economic status, race, cultural background, intellectual or other disability, mental illness, age, gender, sexual preference or geographic location. People have access to an appropriate mix of health services, as well as funded services provided in appropriate locations by a range of health care providers, including nurses and midwives.

Investment is made in innovations such as tele-health, e-health and other means of providing information, support and access to primary health care services to people disadvantaged by geographic, socio-economic, language and cultural isolation, health status and disability. This will make information, support and access to primary health care services available to disadvantaged groups and also to primary health care teams who can then minimise this isolation and maximise their capacity to maintain or restore the health of these people.

In doing so nurses and midwives support continuing the considerable investment to 'close the gap' for Aboriginal and Torres Strait Islander peoples in improving health outcomes, recognising investment in primary health care is the most effective means of achieving this important goal.⁸

This also recognises the evidence that health outcomes for specific groups from lower socio-economic groups, people with mental illness, people with disabilities, prisoners and people in detention are significantly poorer than for other populations and investment in these populations is commensurate with their poorer health.

EDUCATION

All primary health care workers are suitably educated socially, professionally and technically to work as a part of a primary health care team and to respond to the expressed health needs of the community. This includes nurses, midwives, medical practitioners, allied health professionals, Aboriginal health workers, assistants and community workers, as well as traditional practitioners.⁴

Effective transdisciplinary primary health care requires pre-entry and ongoing integrated inter-professional development and education. This is achieved by the incorporation of transdisciplinary education into the curricula of all the health professions, so a cooperative and collaborative approach to primary health care practice between nursing and midwifery students, medical students and students of other health professions is present right from the beginning and throughout their careers.

The development of integrated undergraduate, postgraduate, and clinical education curricula assists in the promotion and extension of inter-professional recognition, understanding and cooperation.¹⁴

Planning for the future means Australia extends beyond 'self sufficiency' in skills development to educate, not only the health professionals Australia needs but also to contribute to the health of our region.

A dynamic approach to the education of health professionals in primary health care is required to ensure the workforce is prepared to meet changing needs.⁷

INNOVATIVE MODELS OF PRIMARY HEALTH CARE

A number of factors are critical to developing appropriate models of care, improving services and the health of the people in that community. These include 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.

Services and care are based on the best available evidence and delivered by the most appropriate health professional or worker. Effectiveness of primary health care demands a culture of reflective improvement and innovation and a continuous cycle of development and implementation of health services research. This needs to inform the development of health policy and increase the effectiveness of health service delivery on an ongoing basis.

Investing in research to provide strong evidence on which to develop improved models of primary health care is critical. Research is designed to obtain evidence that is sensitive to the particular health needs of the population/community being studied. This recognises the diversity of primary health care needs and the variety of models of care that may be appropriate to different communities.

GOVERNANCE AND FUNDING OF PRIMARY HEALTH CARE

There is a balanced and effective use of both public and private resources. New technologies are evaluated in a timely manner, and where shown to be cost effective, are implemented promptly and equitably.

Midwives and nurses support comprehensive, accessible and universal health care services available for everyone living in Australia, with effective primary health care fully integrated into

the broader health system, forming the nucleus of the system. The governance and funding of primary health care requires national leadership through sound national integrated health and funding policies that allow flexibility to meet the needs of local communities.

Nurses and midwives support the principle that governance responsibility should be vested in local communities to enable sensitivity to local needs. This will be driven by active community participation in design, planning, implementation, monitoring and evaluation of primary health care services. The 'pointy end' of accountability needs to be close to the community, while also transparent to Government and other oversight agencies so that the means and the ends are apparent. Primary health care is funded by one universal funding system for health, with funds generated through the national taxation system. Funding for services, programs, care and treatment is based on the population health needs of the community and individuals; and are designed to promote the goals of primary health care enabling the maintenance of health, continuity of care and transdisciplinary care. This requires investment to create supportive environments and policies that promote and protect our health and prevent disease and injury in order to maximise people's potential to achieve optimal health.

Primary health care funding is based on the demonstration of positive health outcomes for people and communities; promotion of teamwork and collaboration;¹⁵ and cost effectiveness.

People in partnerships of care with nurses and midwives and other health professionals have direct access to funding to cover all aspects of their primary health care without the process being 'for and on behalf of' a third party.



Photo: Courtesy of APNA

SAFETY AND QUALITY

Effective systems of corporate and clinical governance are necessary at all levels of primary health care to monitor and improve the safety and quality of services. This includes:

- open, transparent monitoring and reporting systems
- collection and use of data and information for driving change and improvement with performance indicators based upon the social determinants of health and other evidence based quality indicators of access, safety, effectiveness, appropriateness, efficiency and consumer participation
- investment in research for achieving continuous improvement
- effective organisational systems that promote safety and quality
- robust regulation of the conduct, health and performance in professional practice of health professionals
- strong consumer participation in all processes
- occupational health and safety.

SUSTAINABILITY

There is a dynamic primary health care policy environment to support the health system to implement strategies to support continuous innovation, integration of new programs and ensure health policy adapts to meet community needs as they change over time. To do this there is an adequately resourced health sector, ensuring that the primary health care workforce is valued and appropriately supported.⁷

As well as adequate resources, the funding cycles are appropriate to ensure continuity of successful programs as well as enabling innovative new programs to demonstrate their potential.

Primary health care in action | First Aboriginal nurse practitioner leads community care in dialysis



This New South Wales regional community dialysis service supports around 300 Aboriginal and non-Indigenous clients receiving renal replacement therapy for end-stage kidney failure in the form of haemodialysis or peritoneal dialysis. The people are cared for either at home or in one of five community satellite dialysis units within the 31,000 sq km covered by Lower Sector Hunter New England Health. None of these settings has a medical practitioner present; the program is run by Aboriginal nurse practitioner Lesley Salem, who also works nationally with the Aboriginal and Torres Strait Islander peoples who have chronic and end-stage kidney disease. The aim of the program is to provide renal replacement therapy and prevent complications of the outcomes, co-morbidities and causal diseases of kidney disease and renal replacement therapy, while maintaining the quality of life that suits the person receiving care. Lesley covers all the centres with phone contact 16 hours a day; renal nurses staff the satellite dialysis units and run a home visiting service; a nephrologist visits one centre once a week; a dietitian visits one centre once a week; and a social worker visits one centre three times a week. The program is funded through the Department of Nephrology; funds have also been raised through charity groups, pharmaceutical companies, non-governmental organisations,

friends and families. These have supported related projects such as a bush tucker farm with a local high school, and a book written by the nurse practitioner to help Indigenous community members eat their traditional 'bush tucker' healthily when they have kidney disease and diabetes.

The service provided by nurse practitioner Lesley Salem is important in many ways. It supports people with renal disease; provides clinical support for nurses that was previously absent; provides an interface between the primary health care providers (general medical practitioners, practice nurses, community nurses and Aboriginal health workers); gives continuing professional development to other nurses; validates effective nurse-led medical models; and offers a vision of preventive primary health care strategies. Lesley Salem was innovative in being not only the first nephrology nurse practitioner in Australia but also the first Aboriginal nurse practitioner. She has raised professional and public awareness and facilitated achievement of initiatives beyond the job description, helping to establish projects that reflect the social conscience of the nursing profession.

Source: Chiarella EM (2008) *New and emerging nurse-led models of primary health care - Discussion Paper for the National Health and Hospitals Reform Commission*, Canberra, 27.

Nephrology Nurse Practitioner Lesley Salem - New South Wales



Primary health care in action | Reliable mental health services for Indigenous people in remote areas

A team of Northern Territory health workers including remote area mental health nurses providing specialist mental health services to Indigenous communities, is having a positive impact on mental health outcomes at the local level. Remote area mental health nurse and nurse practitioner candidate, Deb Spurgeon says the nurses' services are provided according to community need. "We visit various communities once a month and the visit could last for up to a week depending on the location and level of demand for mental health services. We use a consultation liaison model which provides specialist assessment, review, monitoring and collaboration with primary health care providers to plan ongoing management and intervention," Deb said. "But the basic premise to this is that mental health is one component of holistic health care and we provide guidance and advanced level support to local health care providers within a primary health care model."

One of the main benefits of the service, according to Deb, is that Indigenous people are receiving reliable, long term treatment and gaining stability which enhances family and community life. "Being able to engage Indigenous people in longer term treatment can offer some relief from the distressing symptoms of mental illness which affects entire families and communities. It can help people improve their ability to function within families and communities because they are well and managing their illness," Deb said.

The specialist mental health service has been well received with community members actively seeking support. "I find now that people know who we are and have seen the positive impact of our services in the community, we are often

directly approached for help. Sometimes when I arrive at the airport I have families waiting to see me and asking if I will see a family member."

Deb says commitment, consistency and reliability are key to the success of the service. "I have a favourite saying about primary health care services, 'If you can't sustain it, don't start it'. Our service works because we have proven ourselves to be effective in the community. We keep coming back and have a great level of commitment to helping people get well and stay well. As a result of our work people are getting a greater understanding of mental illness and mental health problems. This in turn helps families and communities with awareness levels and makes it easier to intervene early and achieve better outcomes."

Mental health nurse and nurse practitioner candidate Deb Spurgeon - Northern Territory





A nurse-led pilot project at Flinders Medical Centre (FMC) in South Australia has improved health outcomes for Indigenous patients travelling from remote areas for cardiac surgery. It is hoped the project will be extended to all major tertiary hospitals in Australia.

South Australian based nurse Monica Lawrence began researching the trajectory of cardiac care being delivered to Indigenous patients at FMC after identifying gaps in patient care. "As a nurse at the coalface I had concerns that the care of Indigenous people might be compromised due to a lack of understanding and cultural awareness," Monica said. "This led me to undertake a Masters that focused on how to improve care and also find out why so many people failed to show up for surgery for chronic illnesses."

In crude figures 21 out of 48 patients scheduled for surgery didn't show up over a six month period in 2004-2005. The remote area nurse liaison pilot project reduced the no shows to zero by 2007.

Ms Lawrence's research revealed that many Indigenous patients attending the hospital for surgery were psychologically and clinically

unprepared. "A lot of people had their surgery cancelled because they weren't prepared and I thought there must be way of preventing this problem. I observed the reasons surgery was cancelled over a four week timeframe and found the majority weren't dentally fit and were at increased risk of endocarditis. There were a range of other reasons surgery was delayed, including inappropriate carers accompanying the patients."

Ms Lawrence said many Indigenous patients were not properly informed and prepared for surgery due to language difficulties. She confirmed that simple strategies to improve communication between the hospital and local communities made a great contribution to improving attendance rates and successful outcomes. A key aspect of the pilot project was the simple exchange of information and taking the patient and key care providers through the journey from community to hospital and back to their local community again, Ms Lawrence said. "We transferred knowledge about clinical cardiac issues and rehabilitation to the patients, their carers and health workers in local communities and we gained important local cultural awareness in exchange."

Nurse Monica Lawrence with clients from remote area communities - South Australia



Achieving the vision

This consensus view intentionally challenges the status quo. It highlights the principles that underpin primary health care and the contribution that nurses and midwives can make to realising this long term international goal set out in the Declaration of Alma Ata.

Our enhanced vision for the delivery of primary health care to the Australian population requires acknowledgement at both government and policy levels that nurses and midwives are capable of, and do make autonomous decisions that legally and politically are not 'for and on behalf of' any other party. In addition, equitable funding mechanisms must be developed to facilitate the increased deployment of registered nurses, midwives and nurse practitioners in primary health care services and for the community to have access to subsidised medicines and services provided by those professionals.

Funding reform will also enable other health professionals and workers to work more effectively in a transdisciplinary team.

A considerable number of nurses and midwives already work in health care environments that are identifiably primary care and primary health care settings, employed in both generalist and specialist roles as aged and community care nurses, maternal and child health nurses, practice nurses (working in general practices), mental health nurses, community health nurses, community midwives, school nurses, women's health nurses, men's health nurses, occupational health nurses, rural nurses and midwives, remote area nurses, sexual

health nurses and public health nurses. These nurses and midwives are registered nurses, registered midwives, nurse practitioners and enrolled nurses.

Recognition of the role nurses and midwives can contribute in primary health care is increasing nationally^{6,10} and internationally¹⁶⁻¹⁸ and is seen as essential to achieving improved population health outcomes and better access to primary health care services for communities. While the literature and evidence on the contributions of nurses and midwives in the multiplicity of primary health care settings in which they work has been rare in the past, the work that is now being undertaken to document this also opens up the potential for many more innovative models of care in a wide range of settings.^{5,10,17,18} Broadening the role of nurses and midwives, as with other health workers enables the human service sector to work with communities to focus on the prevention of illness and health promotion; and offers an opportunity to improve the management of chronic disease as well as reduce demand on the acute hospital sector.

Registered nurses* and midwives are regulated health care professionals who provide care in collaboration with other health professionals and other human service workers. They work in a partnership with the local community; people requiring nursing and midwifery care; with their family, friends, relatives and other members of a person's nominated social network. Legislation and regulation guide nursing and midwifery practice, creating obligations and sanctions that are founded on the need to ensure the safety and quality of care provided to the community. Registered nurses and midwives, as qualified licensed professionals, are accountable and responsible for their own actions.

*See endnote 3

Primary health care in action | Making outreach primary health care a priority in Aboriginal and Torres Strait Islander communities

Wendy Flahive has been interested in Aboriginal health issues ever since a camping trip many years ago when she took the kids on a 'round Australia education tour' of our magnificent country. To extend the trip for three months she worked at a community controlled Aboriginal health service near Cairns, in Far North Queensland, for six weeks. Wendy was shocked by the poverty, disadvantage and the medical model of care working 'downstream' patching local people up and sending them home again without any longer term, preventative care.

More recently, Wendy has worked for three years at an Aboriginal community controlled service with a small team of primary health care workers, in rural Victoria. In this service with a largely town based population her focus was primary health care, taking the baby scales to the families, immunising in the homes. She worked wherever she was able to access families with children. At this time Wendy was able to develop flexible working arrangements and visit families that were disempowered, disadvantaged and in many cases affected by the stolen generation issues. It was a time of learning from the people and consolidation. Wendy learned to work from where the people were at in their journey and the rewards were memorable. She developed the skills to deal with abuse and violence and to help empower the women and children.

Wendy recently decided to find out for herself, why, despite so much funding reportedly going to help improve Indigenous health, the health outcomes remain so poor. She chose a two month relieving position as a child health nurse at a remote community in East Kimberley, Western Australia.

What hit her the day she walked into the health service was the amazing work being done by all

the health workers, administration and support staff working every bit as hard under difficult conditions. It struck Wendy that nothing had really changed since her experience nearly 18 years earlier, except this huge expectation that Aboriginal health services provide more primary health care in addition to their existing clinical work. To access funding, huge amounts of paper work had been generated to provide evidence that primary health care was a priority. The reality seemed to be health care professionals were still working 'downstream'. Wendy encountered an alarming number of preventable illnesses. She spent much time worming children and addressing issues such as poor diets, scabies, low birth weight and foetal alcohol syndrome. The expectation and work load on staff was enormous. There wasn't nearly enough funding for primary health care outreach work.

The service Wendy worked for in WA has just been granted \$500,000 towards building a health education and promotion unit onsite. Staff and the community hope that this will finally move the service forward to providing much needed outreach care. Allowing health workers to do more home visits and help people in their own environment has proved successful in Victoria. Wendy thinks this is the gold standard in maternal and child health services that all states should aim for.

Wendy Flahive's colleague, nurse Jo Stace (left) with a family and a trainee health worker in Kununurra - Western Australia



While there is an expectation that staff work 'downstream' in underfunded positions in remote communities, wherever they are in Australia, there will be a continuing pattern of ill health and band aid approaches. Paying lip service to primary health care to access funding when health workers are so bogged down with sick families with children makes true primary health care near impossible, though everyone tries their best.

Government funding priorities should be aimed at prevention and primary health care made a priority if we are to improve Indigenous child health. Maternal and child health nurses are in the drivers' seat in Victoria delivering a model of primary prevention that is best practice. Family and child health nurses throughout Australia can offer a level of community care to improve health outcomes in Indigenous communities when working with a primary health care focus.

Source: Flahive, Wendy (2009) Expand nurses' roles in primary health for Indigenous people. *The Australian Nursing Journal*, March, 16(8): 23.

CHALLENGES AND DISINCENTIVES

In Australia, the full potential of nurses and midwives to perform vital roles in primary health care in a broad range of contexts and settings has been constrained by significant structural disincentives such as:

- the barriers created by the distribution of powers and functions in relation to health in our Federation
- the lack of a coherent national health policy underpinned by investment in and commitment to the tenets of primary health care
- outmoded models of care perpetuated by national funding policies that are narrow and inflexible in focus

- a powerful oligopoly that has generated anticompetitive lobby groups protecting their commercial interests by using propaganda and political influence to challenge the integrity of nurses and midwives
- the market driven conservatism and risk adversity of recent governments to make substantial and sustainable changes to deal with the inequities that are currently embedded in Australian society.

The politics of health

There are critical aspects within the politics of health in Australia that impact on the ability of the nursing and midwifery professions to achieve their vision of primary health care. Significant impediments to structural reform in health that make the steps to true transformation, such as making primary health care the cornerstone of health policy, arise from the prevailing oligopoly in health.

The oligopoly* of health

There is little doubt over the last century the medical profession has secured its position of power in relation to the design and function of the health system in Australia. As health ministers, principal advisors and policy developers, medical practitioners have had a disproportionate say in the way that health services are delivered and funded; inevitably with medical practitioners as gatekeepers. Also unsurprising is that the profession continues to wield disproportionate authority and influence across the health system in 2009. Nurses and midwives acknowledge that there is a growing body of medical practitioners who recognise the critical need for a much stronger partnership between communities, citizens, health consumers and other health professionals

*See Glossary of Terms

if we are to address the health inequities that continue to exist in our communities.^{7,20,21} However, all these groups recognise that power is not easily surrendered, especially as it is linked to an almost complete commercial monopoly created through the restriction of access to funding sources.

This state of affairs has created a number of extraordinary distortions to the way that the health system functions in Australia. It has led to serious inequities and access problems for communities and individuals and has in turn nurtured the evolution of convoluted hierarchies and professional silos in the health system. These distortions preclude one of the fundamental principles of primary health care being realised - that of transdisciplinary teamwork.

This environment has been perpetuated by successive governments in national, state and territory health and funding policies. It is further exacerbated by some influential sectors of the media who have been captive to a vocal minority of this powerful elite who hold the community to ransom with emotionally charged, provocative and dire warnings of death and mayhem for the Australian community whenever the status quo is challenged.

The myth-based ambit claim of a relatively minor yet vocal group of medical practitioners that nurse or midwife led care, or care led by other health professionals is second class, continues to be made at every point of challenge. For example

when positive stories about nurses, nurse practitioners, midwives, pharmacists and other health professionals are published, there is a predictable and immediate rebuttal arguing that anything other than medical led care is 'the thin edge of the wedge', the 'floodgates opening'; inevitably finishing with the predictable - 'if

nurses or midwives (or other health professionals) want to be doctors they should do medicine'. The mixed messages and tensions created by the sometimes hysterical reporting of health issues do not assist the community to unpick the fact from the fiction. The fact remains that nurses and midwives seek to work to their full potential providing comprehensive health care for people requiring it, taking full

responsibility for their practice as nurses and midwives.

The range of structural factors impeding the efficient and equitable delivery of primary health care include the split in funding between the Australian, state and territory governments; the dominant fee-for-service payment mode; and differential payment arrangements for distinct modalities of care, which create a privileged position for some modalities and delivery settings and yet create access barriers to others. Taken together these foster an episodic, piecemeal and reactive focus to care, that is medically dominated and where the responsiveness of the service system is severely compromised.²²

The publicly funded community health models of care that were evolving in Australia in the

The myth of meritocracy

Merit is defined by people in power to reward what people in power become. Merit, as we know it, explicitly values particular experiences and abilities - the ones developed by people in power - and therefore implicitly devalues others... Meritocracy calls those who conform to these standards 'equal'. Those who are different, it calls 'unqualified'. Chiarella (after Murray) (2002)¹⁹

1970s and 1980s and showed great promise remain underdeveloped in most places. Instead the general medical practice model of primary care tends to be the predominant model that is identified by the community at large as the main way that primary health care is delivered in Australia in 2009.

The current system of primary care funding in Australia creates serious barriers to effective health promotion and chronic disease management, and limits its effectiveness in terms of equity, access and value for money. At present in Australia, models of primary care are limited in focus, and not always based on the best available evidence. Consequently, change has been largely driven by strategies that are more about defusing overtly political crises, rather than positive health outcomes for people, efficient and sustainable service delivery models, or cost effective care.⁷

The inability of midwives working in private practice to obtain professional indemnity insurance to cover their practice has effectively removed midwifery-led private services from the list of choices that women and their families may make in relation to primary health care maternity services.

A significant proportion of primary care is offered through general medical practices and is identifiably primary care (as distinguished from primary health care) founded on a market-based funding model of fee-for-service. The fee-for-service system creates a perverse incentive to provide more, but not necessarily better, services. It creates a financial incentive to provide many services, not make people better. It also acts as a barrier to integrated services: as a stand-alone service, there is nothing to oblige these services to interact and integrate with any other health service.⁷

Referral patterns tend to be to other medical specialists and some allied health professionals, but the evidence shows that the potential for

referral to secondary, non-medical or other relevant services is not realised.⁶

While primary care can provide continuity of care, especially with visionary GPs and other health professionals such as practice nurses working with them, primary care providers are focused on early diagnosis and timely, effective treatment. That is where the incentives are loaded in the current Medicare, MBS and PBS funding systems. There are only limited incentives built into this predominantly market based fee-for-service system to encourage health promotional, disease and injury prevention education or consumer disease self-management education and support strategies. Opportunities for developing partnerships with other sector agencies to address the social determinants of health that are outside the sphere of the health system are also limited.

Fertile ground for innovation in models of service provision and funding

It is of note that the more extraordinary and innovative models of primary health care in Australia have emerged to some extent in order to counterbalance the deficits and have developed despite the prevailing funding mechanisms in health. There is also increasing evidence that shows funding based upon fee-for-service, task-based components strongly discourages a collaborative approach to health care provision. By contrast this research found that teamwork and collaboration were promoted where health services, not individual practitioners, were 'bulk-funded' for capitated health care provision.¹⁵

The burden of making a commercial success of medical practice in smaller rural communities and remote areas while balancing the demands of family and lifestyle choices, with little back-up and support has meant that the medical presence in many rural and remote communities has been

diminishing over time and is non-existent in others. Seriously disadvantaged groups such as culturally and linguistically diverse communities, people with chronic mental illness and homeless people have also fallen outside the commercial model of primary care that is the norm in our society.

Governments and communities have had to invest and get involved to ensure that access to some level of primary health services is available. This has led to rural and remote and disadvantaged communities in Australia generating the impetus for the development of some unique and successful models of care and blended funding.

Community controlled health services are a model for primary health care that explicitly vests power in local communities.

Aboriginal and Torres Strait primary health care services

Closing the gap for Aboriginal and Torres Strait Islander peoples in urban, rural and remote areas has led the Prime Minister of Australia to issue the following challenge:

"We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services."²³

Community controlled primary health care services have already been adopted strongly by Aboriginal and Torres Strait Islander peoples in urban, rural and remote communities this form of service delivery has proved successful in making significant improvements to the health of individual people and the community as a whole, and where other models may have been less successful. The services are developed around the population

needs of the specific communities and will often have a range of health service providers traversing both the health and social welfare sectors. Skilled nurses and midwives work with Aboriginal health workers, doctors, dentists, dental hygienists, nutritionists, other allied health workers, housing coordinators, counsellors, drug and alcohol workers, mental health nurses, public health nurses, maternal and child health nurses, school nurses, primary health care nurse practitioners, aged care nurses and practice nurses, among others.⁸

The overarching ideal of a primary health care strategy involving Aboriginal and Torres Strait Islander peoples must be the recognition of strengths, not only the disadvantage.

Aboriginal and Torres Strait Islander peoples have survived and have a long and living culture, despite past policies. Their communities have great strengths. Primary health care nursing is about engagement at many levels, including engaging, supporting and working with the strengths, resources and the health workforce of Aboriginal and Torres Strait Islander people.

The Congress of Aboriginal and Torres Strait Nurses (CATSIN) are of the view nurses in primary health care teams have a responsibility to utilise the expertise across the team, and consistent to the needs and the wishes of the client. Nurses also need to acknowledge and respect the specialised knowledge and skills of the Aboriginal health worker (AHW); and need to be self aware about the skills they may lack, and acknowledge the rights of others, around the provision of culturally appropriate care⁸

Within Aboriginal community controlled health services, the AHWs may benefit from the assistance of suitably qualified nurses and midwives who are skilled in managing complex, ongoing co-morbidities that require advanced technical and clinical knowledge and experience.⁸

Innovation in other areas of primary health care

Other unique specialist primary health care services have also emerged in Australia due to identified community needs and often the activism of the community and health professionals who recognised and supported the causes. The development of the original baby health centres (now maternal and child health services), women's health and reproductive services (family planning) services, gay and lesbian health services, community crisis and mental health services and health services for refugees, immigrants and asylum seekers are all examples of primary health care services with strong community commitment, often resourced initially by community contributions of volunteer labour and sometimes funds.

However, it should be noted that, when first established, many of these services were supported by one-off funding grants, precarious recurrent funding contracts or direct community contribution. For many this proved fatal to their ongoing capacity to continue providing what were often important health services. Others found ways to access traditional funding sources, which in many cases compromised the innovative model of care that had been a feature of their success with the particular community they served. Promoted by governments and communities and generally tolerated by the medical profession, it is difficult to sustain the ethics of the argument that multidisciplinary, population needs-based services such as these are not appropriate for the general community. We know that co-payments are a disincentive for people seeking primary care when their health problem may be potential, latent or in an early stage. We also know that many in our community with chronic and complex care needs are not served well by our current primary care system - often leading to admission

to acute hospitals with recognisably preventable antecedents.^{7,22,24}

If we do not believe that second class primary health care services are 'OK' for our most needy; why don't we open up models of transdisciplinary primary health care for all people living in Australia?

The current systems for health funding in Australia create serious barriers to effective health promotion and chronic disease management, and limit effectiveness in terms of equity, access and value for money. Except in extraordinary cases, the community has little input or control in relation to health strategies that directly affect them. The models of promotion, prevention, care and treatment are not always based on the best available evidence. We know there are major discrepancies in their efficiency and cost effectiveness. The current modalities do not necessarily provide positive outcomes for people and their communities; and sustainable, replicable service delivery remains a challenge. Funding models for good health should support sound health policy designed to meet population needs. They should not dictate the policy simply because they are embedded in legislation and government structures and presumed to be inviolable.

Nurses and midwives continue to be ethically challenged and professionally discouraged when governments develop and fund new models of care that are restricted to rural and remote communities or to other disadvantaged groups in the community. This is not because they are not required; nor because they are not high quality safe services; but because it implies they are not as good as the services for the rest of the community, a view underscored by the vocal minority in the medical profession in their response to non-traditional or non-medical led services. Ironically it may be the communities served by the traditional models of primary care that miss out.

Primary health care in action | Dealing with sexual health up front

David Lee was endorsed as the first sexual health nurse practitioner in Victoria in 2008 following two years of preparation and medical mentorship. Matiu Bush is a nurse practitioner candidate completing his Masters of Public Health. Both work at the Melbourne Sexual Health Centre.

Matiu and David believe that the sexual health nurse practitioner model practices at the fusion point of clinical expertise, best research evidence and practice wisdom. The sexual health nurse practitioners aim to provide an innovative approach to the management, treatment and prevention of sexually transmitted infections.

Although bringing prevention, management and treatment to marginalised groups currently not serviced by mainstream health care services has

always been part of the nurse practitioner culture, Matiu believes the nurse practitioner role is broader.

"For us the nurse practitioner role is more than just filling the gap in service provision, being a nurse practitioner is about contributing to the clinical team at all levels, from research to education and always with an innovative edge.

"Although the nurse practitioners provide extended clinical services we have realised that working alongside medical practitioners and nurses is a way of cementing our value in our workplace."

For the first time in Victoria, sexual health nurse practitioners will be able to prescribe HIV medication for non-occupation post exposure prophylaxis (NPEP). NPEP is a course of antiretroviral medication given within 72 hours after unprotected sex with a high-risk person. NPEP aims to prevent HIV seroconversion.

Rates of NPEP uptake in gay men have increased. David sees this as an important area for expansion of practice as few locations offer NPEP in Melbourne.

"NPEP is another strategy available to prevent further spread of HIV."

He is adamant that the safe sex message should not be lost and that NPEP should not be regarded as a morning after pill for gay men. "Victoria is experiencing increased rates of syphilis and other sexually transmitted infections especially in gay men. Sexual health nurse practitioners are an important workforce development in strengthening control and treatment of sexually transmitted infections in Victoria."



Nurse practitioner David Lee and nurse practitioner candidate Matiu Bush - Victoria

SUCCESSSES AND INCENTIVES - Current nursing and midwifery initiatives in primary health care in Australia

The contributions of nurses and midwives form the backbone of primary health care services worldwide, although in Australia much of this contribution has been of an ad hoc nature and has therefore not come to prominence in the same way as in other developed and developing countries.^{25,26} There is a real need for policy, funding and education that creates a space for nurses and midwives to deliver effective and equitable primary health care services.^{10,27}

As outlined above and as the real stories of nurses and midwives included in this paper demonstrate, many extraordinary and innovative models of primary health care in Australia have emerged where identified community needs exist. Where this occurs it is often the result of activism in the community and/or recognition by health professionals who support the cause. The imperative for security of ongoing funding and government support has often meant the innovative models of care the services may have been founded upon, have had to be compromised as they are forced to capitulate to fit into the existing constrictive funding arrangements.

Nurse practitioners in primary health care - loads of potential

The development of the nurse practitioner role in Australia since the early 1990s has continued to demonstrate the most extraordinary potential for the provision of flexible, high quality, safe primary health care by professionals with expert skills knowledge and experience.²⁸⁻³³ However, this potential has continued to be unrealised because of the structural disincentives described above and below; and time and again in any research involving the introduction of the role in Australia.³⁴⁻³⁶

There is also a growing body of international research that supports the fact that health outcomes for people who are cared for by nurse practitioners are at least equivalent to those of medical practitioners and that high levels of client satisfaction with nurse practitioner care are demonstrated.³⁷

Safeguards for the community

There appears to be an unwarranted and unhealthy fear that nurse practitioners will run amok if the constraints are removed. The reality could not be more different. A robust regulatory, common law, policy and risk management framework regulates the conduct, health and professional performance of all health professionals in Australia. The reality is unequivocal - the greater the knowledge, skills and experience; the greater the potential liability of the health professional. The liability of a nurse practitioner who practices outside their scope of practice is already clearly articulated by the Codes of Professional Conduct and Ethics, National Competency Standards for the nurse practitioner, the decision making framework and professional conduct provisions of the legislation governing nurses and midwives in each jurisdiction. In most organisations in 2009 there are also significant other standard clinical governance strategies in place such as clinical review, performance management and other risk management initiatives that provide appropriate safeguards around the quality and safety of nurse practitioners' practice.

Notwithstanding these structural safeguards, currently there are further layers of paralysing requirements for a nurse to become authorised as a nurse practitioner. For example, the policies governing prescribing by nurse practitioners and ordering diagnostic investigations in a number of jurisdictions are significant disincentives for the individual health professional, their colleagues in the clinical team and their employer. Often these



Photo: Courtesy of APNA

policies are connected to the authorisation processes of the nursing and midwifery regulatory authorities and the convoluted processes authorised nurse practitioners have to go through to prescribe medications or investigations, such as developing unique personal formularies and clinical protocols. Another major structural barrier to the introduction of nurse practitioners has been the failure of the state or territory, or the health service to introduce the role as part of a standardised clinical planning process designed to identify communities' population health needs and the best means to meet these. Then there is the political challenge of introducing the role and the predictable opposition from some quarters that can be personally confronting. This substantially has meant that the nurse practitioner has remained an exotic species of health professional whose potential is recognised by many; but where the commitment and investment has not been made to develop the critical mass of them to overcome the barriers that beset the 'exotic'.

In the reviews conducted to date there has been unanimity in recommending as a matter of equity that the state and territory governments address the over zealous constraints applying to nurse practitioners being able to work to their full potential; and work with the Australian Government to provide access to the Pharmaceutical Benefits Scheme (PBS) and Medical Benefits Scheme (MBS) for nurse practitioners to enable the provision of appropriate medications and diagnostic investigations to people requiring them.³⁴⁻³⁶

Primary health care in action | A song to promote sexual health

An innovative project to encourage young people to have a sexual health check up, developed by Donna Muscardin and Julie Elmes, has increased youth screening by 25%.

Sexual health clinical nurse consultant at Hunter New England Area Health Service, NSW, Donna developed a song to encourage young people to get a sexual health checkup. She organised live interviews about the project at radio stations, produced a CD and used the experience to promote the role of sexual health HIV nurse practitioners in New South Wales.

The finished CD includes the song track 'Check me out' and has been marketed to local radio stations in Australia and New Zealand through the Australasian Sexual Health and HIV Nurses Association.

Although she became authorised as a nurse practitioner in 2005, as NSW Chair of the Australian College of Nurse Practitioners, Donna has lobbied for five years for the development of nurse practitioner positions across the state. She continues to work as a clinical nurse consultant and is not employed as a nurse practitioner.

As a clinical nurse consultant Donna does not have access to the MBS or PBS which means her patients miss out on some treatment options.

The traditional managerial separation of sexual health, women's health and family planning restricts Donna in providing opportunistic and preventive primary health care in all of these areas as pap smears and contraception are not recognised as her current sexual health role. "It's crazy, you don't go to a different GP for each treatment. We are talking about having new models of care and this is one area where health outcomes could be more integrated."

Donna says there have been two patients in the past two years under 16 years who have become pregnant after she was unable to provide the pill as it is not on her formulary.

As Donna's role involves sexual health, HIV and Hepatitis C she would like to see more preventative health treatment targeted towards these areas and young people. Donna is well placed to promote MBS and PBS access to nurse practitioners through her role as NSW Chair of the Australian College of Nurse Practitioners.

Clinical nurse consultant and nurse practitioner Donna Muscardin - New South Wales



Primary health care in action | Nurse practitioners help older people avoid traumatic hospital admissions and save community resources

The north coast of New South Wales has one of the highest concentrations of older Australians, with a quarter of the population of Port Macquarie aged over 65 years. It's here that Debbie Deasey works as a transitional (trainee) nurse practitioner treating the elderly in their homes and residential aged care facilities and keeping them away from the emergency department at Port Macquarie Base Hospital.

Working from the hospital and with the help of her 'very supportive' GP mentors, Debbie assesses and, where necessary, prescribes medication, which is then authorised through the GPs (this will change next year when she becomes an authorised NP). "So if someone's aged over 70 and can't access their GP, I'll go out and help treat them for a variety of things, including pneumonia, infections, delirium or checking catheters."

A local girl who started as a hospital cleaner around 16 years ago, Debbie completed her registered nursing studies before undertaking a Masters in Gerontology. She began work as a transitional aged care nurse practitioner in October 2007, and loves the choice it gives the elderly. "The person is safe, the staff are happy

and it prevents an ambulance trip and an emergency presentation." The other benefit for the person is a next day review of the treatment and the extra time Debbie can take as a nurse practitioner. "They like that one-on-one service - they can ask questions and I'm not as rushed as a GP."

"I'm also looking at the people from a nursing perspective, so I take into account the family, the environment, medications and the education I can provide," she says.

"It also empowers the residential facilities by enabling them to get a nurse practitioner in straight away to take care of something straightforward like dehydration." Debbie would love to see more nurse practitioners working in aged care within residential facilities and in the community. But she says easing up the restrictions on PBS and MBS benefits access is crucial to this expansion.

The NSW Department of Health has estimated Debbie's work has saved the hospital \$1.5 million in hospital admissions for over 65s.

Nurse practitioner candidate Debbie Deasey and Dr Alan Forrester
Director of Emergency Department - New South Wales



Primary health care in action | Nurse practitioners providing effective and efficient aged care

Nurse practitioners are not only improving care but saving thousands of dollars by reducing hospital admissions, an ACT Health report shows.

The analysis of two ACT nurse practitioners showed not only did they provide timely interventions and improve patient outcomes, but resulted in substantial cost savings.

A six-month snapshot of a nurse practitioner working both in a major tertiary hospital and in the community in Canberra showed cost savings of \$442,750 through facilitation of 8% (n = 10) of residential aged care facility admissions direct from home not hospital. The report showed the nurse practitioner saved at least 350 bed days at a cost of \$1,265 per day or \$442,750.

Project manager Debbie Hagen, of the ACT Health Office of the Chief Nurse, Nursing and Midwifery Office said this did not include the time before the decision was made. "A person may

already have been in hospital for 30 days which is quite a significant amount of time."

Concerns of cost effectiveness had contributed to the lack of provision of jobs for nurse practitioners, Ms Hagen said. "It is a small study but my argument is one nurse practitioner has saved more than three times her wages and the savings represent just one aspect of her three-year project."

The nurse practitioner working in the private sector in residential aged care service resulted in a cost savings of \$139,000 by reduction in transfers to hospital for treatment. Falls prevention included invisi beams and post fall assessment and processes. "Before these initiatives every resident who fell was transferred to hospital, instead the nurse practitioner would assess every resident who fell and only those assessed with a fracture or laceration to the head for example would be transferred," Ms Hagen said.

Ms Hagen said both nurse practitioners had saved their wages and were not really expensive at all when compared to their results, and were coupled with significantly improved patient outcomes. "Preventing people from going to the ED has significant quality of life benefits. We know how hazardous the emergency department is for older people. Emergency department staff are under so much pressure with trauma and/or a lack of training on the specific needs of older people. This can lead to significant exacerbation of old, and the creation of new problems," Ms Hagen said.

"Nurse practitioners are innovative, cost effective, safe and provide timely quality services in aged care which is evidence based."



Photo courtesy of the Australian Nursing Journal (ANJ)

Dragon, N. (2009) Nurse practitioners save money. *The Australian Nursing Journal*, February, 16(7): 13.

Midwifery and primary health care - a return from the wilderness

Midwives have also proved over centuries that they have a vital role to play in primary health care, working out in the community with women and their infants, families and others close to them from conception into early childhood. Sadly, we have seen a major constriction of that role over the past 75 years with the medicalisation of the very normal act of childbirth and maternity services; made even more profound with the failure of midwives in private practice being able to obtain professional indemnity insurance in the past decade.

Communities, midwives and some of the more innovative primary health care teams have also triumphed in some locations in overcoming at least a number of the structural barriers to enable women, their infants and families to have access to a range of safe, high quality maternity services.

Maternity services review

The rights of the community and women in particular to make choices in relation to maternity services have again been highlighted in the recent Report of the Maternity Services Review.³⁸ The report makes the following important recommendations that will enable the increasing contribution of midwives to the primary health care teams:

- changes to improve choice and availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives, including consideration of changes to Commonwealth funding arrangements and support for professional indemnity insurance for midwives
- changes including an expanded role for midwives to take place within a strong framework of quality and safety

- new national cross-professional guidelines be developed to support collaborative multidisciplinary care in line with best practice, along with a system for advanced midwifery professional requirements
- improved national data collections and targeted research to support a safety and quality framework and allow the impact of changing models of care to be effectively monitored
- changes to support the expansion of collaborative models of care, improved access for rural and Indigenous mothers and reduced workforce pressures (particularly in rural and remote areas of Australia): consideration of targeted additional support to attract and retain a rural maternity workforce-including midwives, GP obstetricians, GP anaesthetists - and improved access to specialist obstetric care
- assisting Australian women in being better able to make decisions about their maternity care by accessing comprehensive reliable information: consideration of better access to a range of information on antenatal, birthing and postnatal care and options, including internet resources and the establishment of a single integrated pregnancy-related telephone support line.³⁸



Photo courtesy of ANJ

Primary health care in action | Nursing and midwifery primary health care in the bush

Vivienne Fazulla is passionate about bush nursing. A remote area nurse for 30 years in her community town of Dingee, about 50 kilometres northwest of Bendigo, Victoria, Vivienne provides primary care "from the womb to the tomb".

The population of Dingee and surrounds of a 20 kilometre radius is 600 and a 45 minute drive in any direction from any major health service.

Vivienne is the manager of the Dingee Bush Nursing Centre and while she provides emergency care, domiciliary, midwifery services, community nursing and education, it is the effects of the 10-year drought on the community that have seen the most innovative health practice.

"We have had a series of different events including entertainment nights, BBQs and afternoon teas to get people together and talking about the drought and the economic downturn and to tell them to hang in there, that times can change," Vivienne said.

Counselling services and other practical support in helping access required services have included appointing a designated person at Centrelink so people do not have to stand in a queue, and a food bank.

Legislative changes and guidelines designed for remote area nurses in Victoria for bush nursing centres have endorsed the work of RANs and enabled them to provide emergency primary health care in the community, including administering certain drugs.

"I had a lady the other day, her husband phoned as she had fallen out of bed and he couldn't wake her up," Vivienne said. "She had had a procedure the day before and suffered with back

pain. We realised she had taken too many MS Contin. I was able to administer Narcan to reverse the effect of the medication - I couldn't have done that without those guidelines in place."

"We have put in a lot of time and effort to have the skills to be able to help people, if we can save one or two people in our career it's worth it."

The greatest impediment to Vivienne's work is the amount of paperwork. "We are just funded to do clinical and there is all this paperwork on accreditation and justification for what we do. It has just mushroomed and every bush nurse manager experiences it."

A broken computer and septic tank are just two of the problems in the previous week that diverted Vivienne's attention away from providing direct clinical care.

The Dingee Bush Nursing Centre was established in 1923. "Bush nursing is really a good model - people 'round here know it's a really good service and they support it, and that's why it works," said Vivienne.

Remote area nurse Vivienne Fazulla - Victoria



Practice nurses making a difference

The renaissance and success of practice nurses working in general practice in Australia has been another significant indicator of the potential of nurses and midwives working in primary health care. The role of practice nurses is well developed in the United Kingdom (UK), Canada and the United States of America (USA). It had been underdeveloped in Australia until the last decade and most particularly in the last five years since direct Government funding has been available for practice nurse activities through the MBS. While the model is largely one of primary care rather than the more liberal and flexible model of primary health care, there is clear evidence that practice nurses themselves have visions of broader horizons.^{6,26,39-43}

An article published in 2007 identified that practice nurses were employed in nearly 60% of Australia's general practices, and are being allocated an increasing number of items in the Medicare Benefits Schedule.⁶ While it is explicit that any services provided by a practice nurse and charged as an MBS item are 'for and on behalf of general practitioners, there is growing evidence that the diversity of roles for practice nurses are expanding. Already a number of practice nurses have entered nurse practitioner education programs, recognising the potential and need for expert primary health care provided by nurse practitioners working in multidisciplinary primary health/primary health care teams of medical practitioners, nurses, midwives, allied health professionals and other health workers.

Australian Practice Nurses Association (APNA) 2008 Best Practice Award winners L-R: Heather Scott, Sara Blackman, Sue Alexander, Sandra Wellwood, Rachel Sargeant and Leone Dunn



Primary health care in action | Nurses and midwives supporting women's health

Rachel Sargeant was surprised to find nurses' roles in general practice quite limited when she first arrived in Australia from the United Kingdom. Rachel won the CSL Biotherapies Best Practice Award for Women's Health in December 2008. The Best Practice Awards are hosted by the Australian Practice Nurses Association.

"I had trained and worked in the UK where midwifery in particular is a little different. In the UK midwives work autonomously in our own clinics separate from the GPs. I was fortunate to be working with a UK trained GP Liz Chappel when I took up the position at Draper Street Family Medical Centre in Cairns four years ago," Rachel explains.

Rachel identified a need for quality midwifery support at the practice and the response was so strong she now has two other midwives supporting the service so more mums can be seen. "The demand for midwifery support services in the area became so strong that we decided to run our own clinics. The GPs are very supportive and happy to follow our lead and having both worked in the hospital in Cairns we ring in and refer patients ourselves without having to send them to the GP."

In addition to midwifery support services, Rachel also coordinates regular pap smear services from the clinic. The pap smear recall and reminder system has significantly improved Pap smear compliance in the local area and resulted in a greater understanding of the importance of regular screening. "Despite having two female GPs we suggested nurses could do the pap smears. Initially there was some resistance because it was assumed women would want a GP to do the procedure. Interestingly women were more than happy to see us and continue to do so," Rachel said. "We are highly competent and by providing the care we are qualified for we allow doctors to get on with the work they should be doing."

Practice nurse and midwife Rachel Sargeant (2nd left) with partner and colleagues, Draper St Medical Centre - Queensland



Primary health care in action | Health promotion and prevention in general practice

Leone (Lee) Dunn has been performing health assessments and developing care plans for patients both at the medical practice and in their homes for several years and in that time has become aware that many older patients are lonely and socially isolated. Many others also fail to exercise regularly due to a fear of their environment which could result in a fall or an assault. Lee said that her

interaction with patients in the waiting room also indicated that many others were willing to exercise, especially if it was in a group environment. She commenced the Medical Practice Walking Club two years ago, introduced initially to assist patients to maintain a regular exercise program in a friendly environment. This club, which walks twice a week, provides older patients with exercise

and the possibility to socialise. Over the winter months it became more difficult to walk regularly due to the weather, she said. In order to maintain the impetus for the club, it was decided one rainy day to go to a local café for a cup of coffee instead of walking.

This idea was so well received that it is now a monthly occurrence. This monthly gathering has been opened to other patients who are not able to walk but who have been identified as socially

isolated. Following on from this initiative, Lee organised a Falls Awareness Evening which is now a regular event. Ways of getting out of a chair or off the ground following a fall and how to improve safety in the home are demonstrated and discussed. Lee has been described by her colleagues as invaluable to both the practice and the community, with no financial reward commensurate with her level of dedication and personal commitment to her role as a practice nurse.

Primary health care in action | Continence advice and management in a Queensland rural general practice

During her two years as a general practice nurse, it quickly became obvious to Lynette Field that there was a very real need for additional continence advice amongst the patients using her rural practice. During one on one assessments for those patients requiring 75 plus health assessments or GP Management Plans for chronic disease management, continence issues were raised and discussed. Many patients identified with incontinence had been too embarrassed to discuss the issue further or had never had the opportunity to discuss it at all. Lynette realised

she was in a position to identify problems that patients considered taboo. The problem of incontinence is becoming more prevalent in our ageing population and seriously influences the physical, psychological and social wellbeing of affected individuals. As a trained Continence Advisor, I was perfectly placed to work collaboratively with both the patient and the GP to address this health issue, Lynette said. "I really found it exciting to be able to offer my clinical knowledge to a large percentage of the practice population. The needs of the patients were obvious to me. They needed to be able to share their experiences and problems with someone who would listen, understand and spend time with them, hopefully improving their quality of life." Both faecal and urinary incontinence issues were identified among the patients.

To address the issues identified, a Continence Advisory Service was introduced at the practice. Lynette worked in collaboration with the GP and other service providers, such as the physiotherapist,



Practice nurses Lynette Field and Leone Dunn accepting certificates from William Abboud, Servier Company Representative - Queensland

to offer this additional service. "I wanted to introduce a way to make communication and treatment easier for patients. I obtained many valuable resources from the Continence Foundation which I now have in a brochure rack displayed in my room for all to see and enquire about". Lynette developed and introduced a Continence Assessment Tool for her practice. This tool is used to identify the type of incontinence and to develop strategies to improve management. Following a review visit, continence aids are ordered. Lynette says, "the practice offers a one

stop shop to discuss issues, rather than travelling or being referred elsewhere. This is of major importance in a rural area as many of our patients are finding it harder to drive or obtain transport. Patients are very happy to have a Continence Advisor on their doorstep and not have to travel for the service". Once the service was established, Lynette found she was getting more and more patients by word of mouth. To date this successful service has been operating for two years.

Maternal and child health nurses - taking the terror out of parenting

Maternal and child health nurses are registered nurses, and in many instances midwives, with additional qualifications in maternal and child health and community health. These nurses and midwives offer a range of services in their practice through individual consultations, home visits and group meetings. They provide health education to families to promote health and wellbeing and

prevent illness; offer support and guidance to families while developing parenting skills; assess child growth, development and behaviour at key ages and stages; guide and inform families in relation to family health, breastfeeding, immunisations, nutrition, accident prevention and child behaviour; and provide access to information on child and family services.



Photo courtesy of Victorian Association of Maternal Child Health Nurses

Primary health care in action | Maternal and child health nurses - supporting families from the beginning

Providing the foundation for health and wellbeing in the first months

During those first months of parenting Karen Mainwaring, a maternal and child health nurse, provides support for the whole family. One mother Karen cared for, a general practitioner, had a very medical view of her newborn. Karen said, "the child was healthy but small and a little unsettled. The mother had an extended and supportive family. Her husband, the father, was also a medical specialist. The baby was the first child in the family for a long period of time". By normalising the behaviour of the baby and the periods of crying; providing reassurance with breastfeeding and the baby's growth; emphasising the importance of play, speaking and singing; and encouraging time on the floor as the child grew, Karen led the parents away from seeing any behaviour in terms of illness, as they had been predisposed to doing in their professional lives, and created a view of their child they did not expect. This led the mother to comment to Karen how much more she was enjoying being a parent than she originally expected.



Mother's group brings families and communities together

Two first time mothers, both with the same last name, had given birth at the same hospital on the same day. They connected for the first time, despite receiving each other's flowers when they were in hospital, when they met at Karen Mainwaring's maternal and child health centre for mother's group. They got along famously. Two years later they had consecutive appointments at the maternal and child health centre. Both were bringing their second child in for their first centre visit. Karen said, "they had cared for each other's elder child whilst they were each in hospital for the birth of their second children", such was the level of their friendship. "The first mother proceeded to introduce the second mother to me, forgetting that it was through the new mothers group at the maternal and child health centre that they had first met". The friendship they had forged had assisted in both mother's emotional and practical support for one another in times of need and their contribution to their communities through their joint involvement in playgroup and subsequently preschool. According to Karen, they now attribute all this to that first connection through the maternal and child health centre.

Maternal and child health nurse Karen Mainwaring with baby - Victoria

School nurses frontline primary health care

School nurses provide a primary health care service to primary school aged children (5-12 years of age) and their families encompassing a range of activities directed towards health promotion and prevention of illness and injury; the provision of information; early identification and early intervention for identified health concerns. School nurses have a broad role that goes across clinical care, health counselling, health promotion, school community development activities, networking, resource and referral and general health centre management.

Primary school nurses provide specific health surveillance activities for children at school entry as well as conducting health assessments for all school entrants, and for any students referred by a parent or teacher. In addition to vision screening and hearing testing, health promotion and education activities such as immunisation, safety and injury prevention, nutrition, positive parenting and asthma management are undertaken as group sessions and through daily contact with students, teachers or parents.⁴⁵

Primary school nurses can provide a range of primary health care services to address many of the health and diet related issues facing primary school aged children and their families. Without a school nurse, the responsibility for these services falls to teachers, who already have demanding roles and may be ill equipped to manage health related matters. The partnership between students, parents, teachers and school nurse is an important one in assisting children and youth to understand the notion of 'health', its importance for life and its links with other social determinants of health such as social conduct, education, emotional wellbeing, nutrition, risk taking and skin protection.

Secondary school nurses have an equally challenging and important role in raising awareness and actively engaging with school aged youth and adolescents who believe they are indestructible. The promotion of health and preventative strategies is a critical part of their role; while assisting those students with chronic illnesses and disabilities to perform to their maximum educational potential.

School nurse Catherine Fisers with student Olivia - Victoria



Primary health care in action | Health promotion, illness and injury prevention for students at school, a place of learning



Catherine Fisers, Wales Street Primary School nurse - Victoria

Former intensive care nurse Catherine Fisers is employed at Wales Street Primary School in Thornbury, Victoria. Her position is funded by the parents of students.

With no government funding, the parents fund Catherine's 11am to 3pm five-day-a-week position as school nurse to their approximately 420 students through a term fee.

"With the rate of anaphylaxis, diabetes and obesity on the rise and the amount of time required for managing a raft of health issues, the parents thought it would be better provided by a health professional," says Catherine.

Parents were polled about whether Catherine's role would be funded for the present school year and about 90% of parents were in favour of the school nurse position, an increase from the 60-70% polled before Catherine started.

Catherine may see up to 100 children a week and has a diverse role from providing first aid, including for fractures, infections, headaches, and asthma, to preventative health care for issues such as obesity and diabetes.

In one week, Catherine picked up a tricky, undiagnosed fracture; advised that a child was taking adult medication instead of paediatric; had a new student detected with a peanut allergy referred for assessment; and provided emotional support for a child anxious about his mother who was in hospital. Then it becomes "really busy" when the school is hit by the flu or a stomach bug.

"It is like mini triage, I can have ten children at once and I have to triage them all quickly. A child with an egg on the head may sit there quietly so I have to whip through them all first quickly and see who needs me the most first."

A weekly newsletter written by Catherine for parents provides 'practical reminders' of health care advice, from nutritional tips to the treatment of asthma during the Victorian bushfires. "With the rate of childhood obesity, we need to get in and help children at the primary school level. While I am providing first aid, I am educating them, parents and staff on nutrition and preventative health care."

The role has also freed up teachers previously rostered to provide first aid who now provide a variety of clubs, such as chess and music, and other projects for students.

Catherine won a Commonwealth Bank grant for football goal post protectors as she identified they were causing several injuries and occupational health and safety is a large part of the school nurse role. The physical education teacher and Catherine have established a Health and Physical Education Board. Catherine says school nurses have an important role to play in primary and preventative health care and can make a huge difference. "I think very strongly this job should be in all schools, to provide preventative health care, education and first aid. Teachers have an enormous workload."

Community health nursing - bridging the abyss between home and hospital

Community health nursing has strong foundations in primary health care. The practice is a combination of nursing practice, public health practice, health promotion and primary health care. Community health nurses work with their local communities to prevent illness and promote health, across the lifespan, through the identification of barriers to wellness and the empowerment of people to change unhealthy lifestyles. Through working in partnerships and recognising the actual and potential strengths of families and communities,

community health nurses seek to foster a sense of self-determination and empowerment of clients.

Many community based primary health care services have identified particular health needs in the populations they serve and have developed innovative solutions to meeting those needs with the contribution of community health nurses. There is still great untapped potential for nurses and midwives to develop both generalist and specialised areas of primary health care practice that sit under the traditional rubric of community health nursing.

Primary health care in action | Preventing and managing leg ulcers

An innovative nurse led project is reducing the recurrence of leg ulcers among older people and those with chronic diseases. *Forever Healed* is a project developed by Royal District Nursing Service (RDNS) clinical research coordinator in wound care, Suzanne Kapp and her colleagues. "In 2007/2008 RDNS provided over 6,000 episodes of care to people with leg ulcers," Suzanne said. "An ageing population and an increase in the prevalence of chronic disease tells us that leg ulcers will continue to trouble Australians and put pressure on community health services into the future."

Leg ulcers are estimated to effect 1.1 to 3.0 per thousand of the adult population in Australia and the estimated cost to the health care system is \$3 billion per year. Suzanne and her colleagues at the RDNS identified the potential to improve

the care of people with leg ulcer recurrence and received external funding to develop the *Forever Healed* project. "The project aims to prevent the recurrence of leg ulcers among a vulnerable, at risk group of people while at the same time improving self management techniques and strategies for people with chronic diseases," Suzanne said. "This project fits perfectly within a chronic disease management and active service model framework. As a result it has the potential to inform and improve the long term outcomes for people suffering from lower leg ulceration."

New and existing RDNS clients who are receiving care for a venous leg ulcer have access to the *Forever Healed* project services and an evidence based client education package - *The Leg Ulcer Prevention Program*. "The client education program focuses on assisting patients to be proactive in managing their own care, supported by nurses and regular monitoring of their progress. The prevention program and *Forever Healed* project combined have the potential to help many people who suffer from chronic leg ulcers both manage their condition and prevent the recurrence of ulcers," Suzanne said. "Ultimately projects like these have great outcomes for people with chronic illnesses and also save valuable health care resources."



Community nurse Suzanne Kapp, Royal District Nursing Service - Victoria

Primary health care in action | Problem solving and using initiative in a community setting

Community nurses come from all walks of life. Some are fresh out of university, others have worked in community nursing for years and some have recently migrated from the acute sector. Regardless of their path to community nursing, each nurse brings an eclectic skill set that enables them to provide the highest standard of health and nursing care. Hayley Morton is one of many community nurses at the Royal District Nursing Service (RDNS) who make a difference to the Melbourne community each day.

Hayley has been with RDNS for just over one year. She visits between 10 and 15 clients in their homes each day for a range of health conditions, and says she enjoys the flexibility she has to make her own decisions.

"At RDNS, I can make decisions based on my own initiative and the nursing care I provide is formulated with my clients' input," says Hayley. However, she explains that the freedom for community nurses to be highly autonomous also comes with broad responsibility.

"Apart from treating conditions, I've also learned to be more intuitive about whether my clients are eating properly, drinking enough fluids, or keeping warm. In community nursing, you are very much involved in a person's life, not just their condition," she says.

She also notes that the ability to be a lateral thinker and problem-solver has helped her adjust to the community nursing environment.

"In this kind of nursing, one must consider all of the influences in a client's situation. What are their socio-economic circumstances? Can they afford to pay for wound dressings? Do they understand how to be involved in managing their condition? These are the challenges that require community nurses to be great problem solvers and very creative in how we deliver care," says Hayley.

Hayley represents one of 1,000 registered district (community) nurses who made 1,608,257 visits to 32,125 Melburnians in the last financial year (2007-8).

Community nurse Hayley Morton, Royal District Nursing Service - Victoria



Primary health care in action | Health ministry team at the ALIVE Centre

Anne van Loon is a faith community nurse* at Blackwood Hills Baptist Church in South Australia, where she coordinates a team of nurses and trained community volunteers to provide health promotion activities/education focused on disease prevention and/or self-management to clients across the lifespan. Anne says, "What we do supplements and complements existing health services. We give people time to talk about their disease and ask questions. We assist them to navigate the health system to locate the most appropriate health or other service to help them with their condition. Anne supports several young people with enduring mental health issues and people going through recovery programs. Anne is supported by a team of community volunteers who provide transport, home visits, meals, tele-care and write letters of encouragement to people. The volunteers are prepared for their role so they can assist clients and their carers effectively.

Faith community nurse Anne van Loon, Blackwood Hills Baptist Church - South Australia



Retired registered nurse and massage therapist, Max Armstrong - South Australia

Anne coordinates a variety of health related activities including exercise programs, a chronic disease self-management course, and specific public education seminars. "We have two rooms at the ALIVE centre and one is set up as a massage room and the other is an office and counselling space". We provide foot care at the centre where we give free foot massages to people aiming to keep our elderly mobile and to reduce stress and give people an opportunity to chat about their health. Max a retired nurse and qualified massage therapist provides free neck and back massages to carers and people with specific health needs, and next month Doreen a qualified infant massage therapist is providing a six week course on baby massage to help parents to settle their babies. "We set up our programs on needs identified by our community and we operate across the lifespan and take a holistic perspective in all we do."

*See endnote 4

Occupational health nursing - safety and care at the work place

Occupational health nursing provides for and delivers health and safety programs and services to workers and community groups. This area of nursing practice focuses on promotion and restoration of health, prevention of illness and injury and protection from work related and environmental hazards. These nurses have an integral role in facilitating and promoting an organisation's on site occupational health program.

The scope of their practice includes disease management, environmental health, emergency preparedness and disaster planning in response to natural, technological and human hazards to work and community environments.

Occupational health nurses provide specialist health and safety advice and run injury management, first aid and emergency preparedness programs. They also develop and provide health education programs, such as exercise and fitness, nutrition and weight control, stress management, smoking cessation, management of chronic illnesses and effective use of health services.

The role of the occupational health nurse includes but is not limited to: case management; counselling and crisis intervention; health promotion; legal and regulatory compliance; worker and workplace hazard detection and business leadership.



Photo courtesy of APNA

Primary health care in action | MERV and a Men's Shed - primary health care for men

Nurse unit manager for primary health care community nursing at Greater Western Area Health Service (GWAHS), Andrew Whale, has spent much of his time working from a caravan called MERV providing primary health care. He is now involved in setting up Australia's largest Men's Shed.

The Men's Educational Rural Van (MERV) is a mobile men's health check-up and information service that travels to workplaces and community sites in the Mudgee district in NSW.

Andrew Whale, said men have their blood pressure, blood glucose and cholesterol levels checked followed by a discussion with a community nurse about men's health issues.

Men are provided with information about heart disease, alcohol consumption, smoking, prostate cancer, bowel cancer, sexual health, testicular self examination, healthy eating, exercise and mental health.

MERV aims to raise the profile of men's health issues and increase the number of men accessing men's health services in the Mudgee local area, said Andrew.

Nurse unit manager Andrew Whale with a client outside MERV - New South Wales

"The response that MERV has received not only in Mudgee but throughout the GWAHS has been overwhelming."

Since the service started in June 2005, 1,246 men accessed MERV and 51 visits were conducted to local worksites or community events.

About half of the men who visited MERV were aged 41-60 and more than one third had not seen a GP for a full health check up within the past year.

Feedback has been positive with 83% of men accessing MERV for a second time and had followed most recommendations made on their first visit.

A local project, community-run and fundraised, which Andrew has been involved in and has taken 15 months to get off the ground, will see Australia's largest Men's Shed built in Mudgee. "It is a way for men to share experiences and skills, just a way to help deal with the isolation and loneliness in the elderly fellow," Andrew said. "Once men leave the workforce, some can lose purpose and direction in life. By getting them together it is mental health by stealth. We get to subtly encourage mental wellbeing."



Education - A vital ingredient in achieving the vision

To encourage a primary health care focus within education and training programs a broad perspective on health and health service delivery is critical. Future teaching models with integration of educational programs around chronic illnesses, communication strategies and lifestyle changes must have high priority and should aim at a transdisciplinary audience. The delivery system must be in a flexible mode. The flexible mode should be reflected in two ways - in the delivery systems and in the teaching staff.

Flexible delivery modes

The course delivery mode needs to be flexible to meet the demands of the target groups that work in busy, low resourced environments often in regional or remote geographical areas.

Integration of innovative teaching modalities such as e-learning is essential and can be combined with onsite teaching components as well as off campus paper based methods. E-learning is particularly attractive as it comes at a relatively modest cost and provides flexibility of access for the students, which are both important incentives for the target group.

Shared academic and clinical teaching model

The teaching model needs to be a shared academic and clinical model, that is current expert practitioners should be invited to teach in academic courses to provide a rich contemporary experience to students. A shared teaching model will also enable academic staff to make links between research and practice and assist the implementation of evidence-based practice. The shared model will also assist in overcoming the current problem of shortage in clinical mentorship.

Nurses and midwives play an integral role in caring for people with chronic illness. In an era of burgeoning chronic disease and with a focus on the central role of the person with chronic illness in managing their condition, the integral role of self management education has been clearly identified as a core component of effective self-care systems.

Supporting education in a sustainable way

The role of education can be supported by the creation of part-time academic-clinical teaching positions. Moreover, ongoing financial and professional support to courses and other professional activities are integral parts of maintaining individual's motivation, providing opportunities to develop skills and knowledge to cope in a changing environment.

Transdisciplinary learning

Transdisciplinary learning needs to be a full part of the educational socialisation so that different professions are able to relate to each other and gain a thorough understanding of each profession's expertise and competencies within primary health care settings. Transdisciplinary education programs at both horizontal and vertical levels are essential to achieve this.

Primary health care units could be integrated across academic undergraduate programs so that nursing, midwifery, medical and allied health students are brought together in both the academic as well as the clinical environments. Professional interactions from the commencement of teaching programs will provide a sustainable way to communicate and understand each others' professional roles in the primary health care setting where team work is vital for good outcomes. In addition, student assessments need to reflect primary health care as a high priority within the teaching program.

Transdisciplinary clinical placements

It is therefore of critical importance that clinical placements are organised so the different student groups work together, for example having mixes of nursing, midwifery, allied health and medical students go into clinical placements together. These students could work around case studies together learning how and when to refer and to communicate with the full health care team, including nurses, midwives medical practitioners, physiotherapists, occupational therapists, health psychologists etc).

Problem-based learning

Experiential teaching approaches that encourage problem solving and evaluation of health outcomes for the individual person, their families and in some cases the whole community are important. The principles of an approach such as problem based learning fit particularly well into primary health care settings as they build on developing inquiry and decision-making skills; collaboration in learning tasks; the development of autonomous learning; contextualisation of problem foci to the practice domain and the encouragement of a thirst for knowledge.

Clinical mentoring

It is critical that the clinical component of the teaching program includes a high level of mentoring. The suggested combination of academic and clinical teaching staff would assist to ensure the transition from universities to clinical environments be as smooth as possible for the students. A smoother transition between the two systems might have a flow on effect in retaining graduates in the primary health care setting.

Ongoing professional education and development in primary health care

A study path clearly focusing on primary health care with specific areas of practice (for example the prevention and management of a specific chronic disease) is important to encourage students to continue working in the primary care settings.

A combined multidisciplinary academic and clinical teaching and learning model creates an excellent foundational model to promote competency based education. There is a need to target specific groups, for example nurses and midwives working in general practice to have more formalised career development opportunities. The preventive role of practice nurses can be greatly expanded and developed into a formalised course structure, for example as a part of a professional development unit. Education programs in chronic disease, including lifestyle issues (asthma, obesity etc) would also enhance primary health care service provision as practice nurses are in an excellent position to educate placed as they are in the primary care setting and their clientele includes a growing number of people with chronic illness.

Other areas of primary health care where nurses and midwives do work or have the potential to work would also benefit from ensuring they have targeted formalised education programs available to them. A collaborative approach with universities and other educational providers should be explored.

It is essential that an affordable, visible and flexible career structure is in place. For example, many nurses and midwives are currently working in primary health care without incentives to further their career by further education. A career structure that supports nurses and midwives in primary health care to further their professional development must be supported by scholarships and directly related to employment levels.

Transdisciplinary interactions in the working environment encourage team work and assist in achieving the common purpose of producing better health outcomes. Good health outcomes for people give confidence and professional satisfaction, which is motivating to health professionals.

Recognition of prior learning and practical experience

Another aspect to consider in meeting the high demands for health care services, combined with and workforce shortage is to make entry levels to educational programs more flexible. For example this requires considering individual cases in terms of professional development courses, work experiences and development within the clinical practice. Evaluating individual cases is particularly pertinent for some areas of clinical need because populations in some regional and remote areas have particular high demands in areas such as the prevention and management of diabetes; yet there is a shortage of adequately educated health professionals to meet those demands.

Many nurses, midwives and health workers have valuable clinical experience and other practical experience that is not being formally recognised by education providers. For example a high level of cultural respect, understanding and sensitivity is required to provide primary health care services in Aboriginal and Torres Strait Islander communities. Aspects of care such as cultural sensitivity, local knowledge and practical experience, are critical in achieving good health outcomes and should therefore be recognised in entry to courses. Educational program providers need to work across institutions (eg between the community centres, TAFE and university sectors) to create a flexible and multi-entry structure that recognises and includes all aspects of experience that add to academic achievements. Providers must be

obliged to give individual applicants advice about how they can achieve their goals in the shortest time.

Taking our place as global citizens - learning from the rest of the world

There are many international exemplars that can provide valuable insight into what could be achieved by actively promoting the role of nurses and midwives in primary health care in Australia.¹⁰ Internationally it is recognised that:

Since nurses and midwives provide up to 80% of PHC⁴⁶, they are ideally placed to provide critically needed, innovative solutions to many global health challenges.¹⁸

The review of international primary health care initiatives involving nurses and midwives for the WHO project - *Now more than ever: the contribution of nurses and midwives to primary care: a compendium of primary health care cases*¹⁷ demonstrates unequivocally the potential for the achievement of the primary health care vision in Australia by using the existing health workforce more cleverly.

Prerequisites for successful primary health care

The compendium outlines case studies that were collected where a service, program or project was able to match the elements of primary health care extracted from the Declaration of Alma-Ata.⁴ Each had to demonstrate that the service, program or project was:

- providing essential health care based on practical, scientifically sound and socially acceptable methods and technology
- universally accessible to individuals and families
- involving full participation of the community

- at a cost that the community and country could afford to maintain
- fostering self-reliance and self-determination
- an integral part of their country's health system and overall development
- providing an entry level for people requiring primary health care services located close to the heart of the community.¹⁷

The work of the WHO compendium and the associated report, *Now more than ever: Nurses, midwives and primary health care, past and present*⁸ provide vivid examples of nurses and midwives practising in ways that incorporate all the key elements of primary health care. The examples go across the following areas and contexts:

Health promotion

- for the elderly and the prevention of non-communicable disease
- food supply and proper nutrition
- adequate supply of safe water and sanitation
- maternal, child and family health

Illness and injury prevention

- maternal, child and family health
- prevention and control of locally endemic diseases
- immunisation
- school health
- community services for mothers and babies
- other aspects of public health nursing

Appropriate treatment of common diseases and illnesses

- Provision of essential medications
- Provision of mental health services
- Tele-health
- Home-based care for HIV/AIDS and Tuberculosis

Preparation and support of an appropriately qualified primary health care workforce

- Establishing community health nursing
- Training community midwives
- Community health practitioners
- Community mental health nursing
- Rural community health nurses

Leadership and advocacy in primary health care

- Nurses and midwives advocating for primary health care
- Developing primary health care leadership
- Community outreach through primary health care nursing and midwifery.^{17,18}

Recurring themes emerged in the WHO case studies that were identified as key contributors to the success of primary health care services where nurses and midwives were involved. It is clear that these align with the elements of primary health care identified in the Declaration of Alma-Ata. Several challenges also emerged that are sadly all too familiar in the current Australian primary care environment. These are summarised on the following pages.

Recurring themes from the World Health Organisation case studies

Firstly, the democratic engagement and empowerment of both staff and community was a key requirement for success identified in most projects. This engagement and empowerment was essential for effective teamwork and accurate needs assessment. Commitment and motivation were essential, and could be built up through culturally appropriate and sensitive engagement with communities. Accurate needs assessment was also required by key stakeholders across service sectors, as the achievement of health was not considered to be the domain solely of health care professionals, planners and policy-makers.

The need to build on existing local resources was seen as critical to success. This was part of the process of recognising that services ought not to be imposed on communities, but developed in response to their identified and owned needs. Ownership of programs by local communities was seen as fundamental to sustainability, and furthermore built self-esteem and self-belief - factors that were also considered essential indicators of good health. Education and information provision were seen as cornerstones of primary health care because they enabled all stakeholders to step up to the mark and meet expectations. This in turn fostered self-esteem and self-belief.

Projects needed to have clear goals and to set out unambiguously the expectations of health professionals and community members. This meant that outcomes could be predicted and measured and expectations could be met and managed. Where projects could not be delivered directly at local level, technological innovation provided access to hard-to-reach groups - but the principles of engagement, empowerment and local needs assessment still applied.

Information and data were also identified as vital. Successful primary health care projects needed to use evidence-based standards, guidelines and interventions; have access to shared electronic records and the internet for obtaining information; and collect good data on outcomes and demographics. Marketing of programs and encouragement through feedback to participants were central for recruitment to and publicity for the programs.

A number of the new educational programs round the world equipping nurses and midwives to take on primary health care roles were identified. The need was emphasised of the value of having faculty engaged in the programs so that students could be rotated through them, thus preparing the recruitment of future cohorts of nurses and midwives into primary health care and building a sustainable workforce.

Two key areas, considered central to the success of the case studies, presented challenges for a number of contributors. These were the issues of reliable and adequate funding and resources, and challenges to narrow thinking about the capacity of staff to take on new roles. The issue of sustainable funding was raised above; access to other resources such as medication, equipment, textbooks and staff also created challenges for contributors. Furthermore, there were a number of reports of medical and some nursing staff having difficulty in letting go of conventional and stereotypical thinking about who ought to perform which tasks.

Adapted from: World Health Organisation (2008) *Now more than ever: the contribution of nurses and midwives to primary health care - Revised final draft* (publication pending), 33-34.

Recurring themes from the World Health Organisation case studies

The WHO has set a Global Health Agenda and makes the point that it requires action in many sectors and at all levels - individual, community, national, regional and global by governments, communities and individuals. They stress it will take strong political will; integrated policies; and broad participation. To deal with some of the underlying determinants of health, a global framework for a health promotion strategy is needed and seven priority areas are highlighted:

1. Investing in health to reduce poverty
2. Building individual and global health security
3. Promoting universal coverage, gender equality, and health related human rights

4. Tackling the determinants of health
5. Strengthening health systems and equitable access
6. Harnessing knowledge, science and technology
7. Strengthening governance, leadership and accountability.⁴⁷

Nurses and midwives in Australia embrace this Global Health Agenda recognising that each priority is manifest in the vision for primary health care outlined in this paper.



Photo courtesy of APNA

Interim measures

Correcting the inequities of access to safe high quality primary health care services in the short term

Without diminishing the need for a more comprehensive and equitable approach to primary health care and supporting funding mechanisms, the nursing and midwifery professions recognise the inevitability of a transition phase, while the policy is fully developed and rolled out.

During any transitional period nurses and midwives are adamant that the significant barriers to access for people to affordable, safe, high quality primary health care must be removed. People requiring care from nurses and midwives continue to be greatly disadvantaged by their inability to claim rebates for primary health services provided directly by these health professionals unless it is 'for and on behalf of' medical practitioners with provider numbers. This inevitably leads to the duplication of services or the inability of nurses and midwives to provide the full scope of the care and services for which they have the knowledge, skills and experience to safely provide.

As a matter of principle nurses and midwives do not support the current Pharmaceutical Benefits Scheme (PBS) and the Medical Benefits Scheme (MBS) fee for service arrangements as the primary funding mechanism for primary health care. However, they do recognise the Schemes cannot be closed down overnight. With this in mind, an important inequity needs to be corrected in the short term by allowing people who use nursing and midwifery services to be directly reimbursed through the PBS and MBS when these services are provided by appropriately qualified, knowledgeable, skilled and experienced professionals.

Incentives for introducing transdisciplinary models of care to primary health care in the short term

Nurses and midwives are of the view that steps can be taken immediately, utilising the current funding system to promote the development of broader transdisciplinary primary health care teams that are able to provide a range of key health services through a single service. For example the current Medicare system has been adapted to enable the employment of practice nurses in general medical practices. Rewarding services for the introduction of other health professionals and a transdisciplinary model of care to improve the access and comprehensiveness of primary health care services for the community would be a credible, achievable interim step.

Involvement in the design, development, provision and evaluation of primary health care in Australia

The professions also note the lack of representative numbers of community and health professional groups other than medical practitioners on key health policy committees, task forces, working groups and reform agencies and call for greater equity in parties providing advice to Government on these important reform initiatives.

A key philosophical tenet of primary health care is empowering people to be the principal agents active in maintaining their own health and managing their own illness, injury or disability. Empowerment comes with understanding, ownership and active engagement in the design of the systems that will enable people to do this. The accountability of government to the community for the expenditure of their tax dollars, the source of the vast majority of

funding for both public and private health services in Australia, also demands that the community has an active role in how the health system functions. Therefore the community must have a say as partners in the design, development, provision and evaluation of all health policy, services, and funding, including primary health care.

Nurses and midwives make up the majority of registered health professionals in Australia and are spread across the broadest range of health services in the most disseminated geographic locations, many of which are frontline primary health care services. Therefore these two professions have a unique and informed contribution to make to the design, development, provision and evaluation of primary health care policy, services, and funding. Regrettably this has been largely overlooked and any contributions made by nurses, midwives and also the allied health professions have tended to be tokenistic and usually as minority contributors in consultation groups for the most part dominated by medical practitioners; or in secondary level consultation processes.

Interim arrangements

For the community's sake, nurses and midwives call for the following interim arrangements:

- The identification of a means of using current funding mechanisms to reward the establishment of transdisciplinary teams in primary health care services eg incentives to be provided to existing general medical practices that pool MBS income and demonstrate the use of broader transdisciplinary primary health care teams.
 - Appropriate representation of the community in the development of the national primary health care policy and funding arrangements.
 - Appropriate representation of nurses and midwives in the development of the national primary health care policy and funding arrangements commensurate with the centrality and potential of their professional roles in the provision of primary health care.
-
- An acknowledgement that appropriately qualified health professionals other than medical practitioners are safe and competent to lead a transdisciplinary primary health care team.
 - All persons receiving health care to obtain Medicare rebates and PBS subsidies for services provided by appropriately qualified health professionals, including nurses and midwives **in their own right**. At present, in most cases MBS funded services can only be provided 'for and on behalf of' health professionals holding provider numbers, usually medical practitioners.

The future for primary health care in Australia

It is imperative to:

- Centre health policy in Australia around primary health care for people throughout their lives - primary health care is demonstrably a person centred, holistic approach incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of accessible, essential, integrated, quality care based upon practical, scientifically sound and socially acceptable methods and technology for all in the Australian community.
- Invest in 'health' by funding health promotion and the prevention of illness and injury - focussing on the social determinants of health.
- Ensure primary health care funding is based on the demonstration of positive health outcomes - for people and communities, the promotion of teamwork and collaboration and cost effectiveness.
- Fund acute health care equitably and sustainably - but recognising acute health care is an 'effect' rather than a 'cause', and therefore it must be linked as an extension of primary health care.
- Establish respectful partnerships between communities and individuals and health care providers, managers, researchers and educators - centred on achieving and maintaining optimum health for all.
- Ensure citizens and others living in Australia participate individually and collectively in the planning and implementation of their health care in a collaborative way - the development and implementation of health policy and primary health care services are based on the maxim 'nothing about us without us'.
- Acknowledge the skills, knowledge and experience of all health professionals, including nurses and midwives and use these in effective transdisciplinary teams that enable individuals and communities to have equitable access to comprehensive primary health care services.
- Invest in transdisciplinary education and research for the health workforce - designed to meet the health needs of the community through primary health care provision.
- Work closely with the non-health organisations and agencies responsible for services that can determine the health status of individual people and communities - for example housing, education, agriculture, water resources and environmental management.
- Focus on the quality and safety of primary health care - with robust governance structures and regulation of health professionals in place for that purpose.

Bumpy road (to recovery)

*"By no means are we out of the woods yet.
But from where we stand,
for the very first time,
we are starting to see glimmers of hope".*

US President Barack Obama
April 2009

Glossary of terms

Interdisciplinary care

Where teams have “a much higher degree of collaboration in care, representatives of multiple professions work together to plan, implement and evaluate the outcomes of health care... the work is characterised by a high degree of cooperation and mutual respect... the team as a whole takes responsibility for program effectiveness and team functioning with leadership functions shared among members. All team members are assumed to be colleagues and there is no hierarchical team organisation.”¹¹

Multidisciplinary care

Where “multiple disciplines work in the same site and serve the same patients but each discipline operates with considerable independence - ie, generates its own assessment and implements it shares information with each other but there is no attempt to generate or implement a common plan. Multidisciplinary teams are also hierarchically organised, with a designated program leader who is responsible for overseeing the program, leading meetings, resolving conflicts, allocating caseload... Team members feel only responsible for the clinical work of their discipline and need not share a sense of responsibility for program function and team effectiveness.”¹¹

Nurse practitioner

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice.⁴⁸

Practice nurse

A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. Practice nurses deliver primary health care in a general practice setting. The environment in which they work is often unpredictable and involves caring for a broad group of people from diverse backgrounds and at all stages of life.^{49,50}

Glossary of terms

Oligopoly

A situation of ownership, control, rule or government by a few. Oligopoly is, in fact, a partial monopoly, and in a market situation refers to a condition where the supply of a commodity is controlled by a few... hence limiting competition.⁵¹

Primary care

“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 practised 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.”⁶

Primary health care

“Essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community”.³

This definition is almost identical to that in the Declaration of Alma-Ata of 1978⁴.

Transdisciplinary care

In a model of transdisciplinary care, managing the continuum from illness to health involves a range of health professionals and workers in the care of the person requiring or receiving care.

The needs of the person, rather than the needs of the professional, dictate what type of health care professional is required to lead the health care team and to coordinate overlapping aspects of care. Transdisciplinary care allows for appropriate use and focus of the expertise of a mix of health care professionals. Primary health care models of care go beyond multidisciplinary and inter-professional collaboration, allowing for greater efficiency of primary health care provision.

Where interdisciplinary involves only the collaboration of multiple disciplines in the assessment and treatment process, transdisciplinary care encompasses the flexibility of role extensions between health care team professionals through cross-disciplinary education. The transdisciplinary approach helps to break down the barriers between professions.^{9,10}

Appendix A | Consensus statement



the Australian College
of Mental Health Nurses Inc.



CONSENSUS STATEMENT

Registered nurse and nurse practitioner role in primary health care

This Consensus Statement reflects the position of the Australian Nursing Federation, the Australian Practice Nurses Association, the Australian Nurse Practitioners Association, the Royal College of Nursing Australia and the Australian College of Mental Health Nurses in relation to the role of the advanced registered nurse and nurse practitioner in primary health care.

The health reform agenda in Australia offers a unique opportunity to consider an alternative model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model to offer comprehensive, patient centred primary health care services.

Primary health care, as identified in the 1978 international Treaty of Alma Ata, recognises the inseparability of health from the social, environmental and economic factors that affect human life. It is characterised by a focus on the promotion of health and the prevention of illness, according to principles of equity, access, and community empowerment, and achieved by care delivered by multidisciplinary teams.

In Australia, a significant aspect of primary health care is offered through general practices although it is important to acknowledge that primary health care involves more than a visit to the GP. A considerable number of nurses work in primary health care settings, employed as maternal and child health nurses, general practice nurses, community health nurses, school nurses, occupational health nurses, rural nurses, remote area nurses, sexual health nurses, mental health nurses both as registered nurses and nurse practitioners.

Expanding the role of nursing in primary health care is increasingly being identified nationally¹ and internationally² as essential to achieving improved population health outcomes and improving access to primary health care services. An expanded role for nurses enables services to focus on the prevention of illness and health promotion, and offers an opportunity to improve the management of chronic disease as well as reduce demand on the acute hospital sector.

The current system of health funding in Australia creates serious barriers to effective health promotion and chronic disease management, and is limiting its effectiveness in terms of equity, access and value for money. Major reform is needed to achieve a model of care that is based on the best available evidence, is efficient and cost effective and provides for positive patient outcomes and sustainable service delivery models.

For registered nurses and nurse practitioners to work to the full scope of their practice in the delivery of primary health care services in Australia, historical, professional and legislative barriers to their practice must be overcome.

Registered nurses are self-regulated health care professionals who provide care in collaboration with other health professionals and individuals requiring nursing care. Legislation and regulation guide nursing practice. Registered nurses, as qualified licensed professionals, are accountable and responsible for their own actions. As such nurses are entitled to identify the nursing care which they are educated, competent and authorised to provide. Nurses are held accountable for their practice by the nurse regulatory authorities, whose role is to protect the public, as is the case for all other regulated health professions.

Appendix A | Consensus statement

-2-

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

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

The nurse practitioner role is differentiated by their extended practice in advanced clinical assessment, prescribing, referral and diagnostics. These extended practice privileges are supported by state and territory legislation. Whilst there are around 300 authorised or endorsed nurse practitioners in Australia, only around half of these nurses are employed in nurse practitioner positions and even less are practising to the full scope of their role. Some of the restrictions on nurse practitioner practice are the lack of positions, an inability for patients to receive subsidised medicines if prescribed by a nurse practitioner (as distinct from a medical practitioner) or rebates from Medicare for nurse practitioner services, limiting their practice and reducing patients' access to affordable, high quality health care.

Registered nurses and nurse practitioners are ideally placed to deliver primary health care in Australia. Nurses in primary health care will not replace other health professionals but will (and do) provide a unique service that they are already well prepared and qualified to offer. This will enable the community to access a level of primary health care that is currently not available to the Australian population.

There is urgent need and immense benefit in reforming primary health care in Australia to fully utilise the expert and effective role of nurses. There is a strong potential not only to deliver improved health outcomes for the community, but also to positively impact national productivity through the utilisation of nurses - the largest professional health workforce in the country.

Our alternate vision for the delivery of primary health care to the Australian population is for the legal capacity of professional nurses to make autonomous decisions to be acknowledged at policy level and equitable funding mechanisms developed to facilitate the increased utilisation of registered nurses and nurse practitioners in publicly funded primary health care services and for patients of nurse practitioners to have access to subsidised medicines.

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Appendix B | The Declaration of Alma-Ata

THE DECLARATION OF ALMA-ATA

International Conference on Primary Health Care, Alma-Ata, USSR

6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

Appendix B | The Declaration of Alma-Ata

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.⁴

Appendix C | The Chiang Mai Declaration 2008

We, more than 700 nurses, midwives, physicians and other professions from 33 countries across all six regions working in healthcare organisations, communities, universities, governments, non-governmental organisations and the private sector, as participants at the International Conference on New Frontiers in Primary Health Care: Role of Nursing and Other Professions, February 4th - 6th, 2008, in Chiang Mai Thailand, unanimously endorse this Chiang Mai Declaration.

This year, 2008, is the 30th anniversary of the Alma Ata Declaration that launched the Primary Health Care (PHC) movement, thereby advancing the health of all people.

We recognise that progress in achieving the Alma Ata goal of health for all has been mixed, considerable advances have been made but still many gaps and inequities exist.

We applaud and join in the United Nations commitment to achieve the Millennium Development Goals (MDGs), recognising that several of which depend upon successful Primary Health Care.

We declare that:

- Nursing and Midwifery is a vital component of the health workforce and are acknowledged professionals who contribute significantly to the achievements of PHC and the MDGs.
- Nurses and midwives can successfully lead health teams that are essential for successful PHC to achieve MDGs.
- PHC and the MDGs will not be fully achieved if the nursing and midwifery workforce continues to be neglected.
- Key PHC policy decisions, at all levels, must involve nursing and midwifery leaders for effective and informed decision-making.
- Nurses and midwives require improved working environments and adequate financial and non-financial incentives, in order for them to be effectively retained and motivated, thus enhancing access to quality health care.

We recommend that:

1. PHC policy frameworks explicitly recognise and include nurses and midwives as critical policy-leaders in decision-making.
2. Legislation be implemented which recognises the full scope of practice of nurses and midwives in community-based care.
3. Educational institutions are strengthened through faculty development, curricular innovations, promotion of research and infrastructure establishment to produce qualified graduates to meet the health needs of their countries.
4. Health systems accord nurses and midwives with key positions that utilise their competencies in all aspects of PHC for achieving the health-related MDGs.
5. Employers, public and private, ensure that nurses and midwives are motivated by adequate financial and non financial incentives, and supported by safe and well-equipped working environments to enhance workforce productivity and retention.
6. Governments and development partners commit to mobilise and allocate sufficient resources to strengthen and upgrade nursing and midwifery education and practice; workforce deployment and development; and improved working conditions, as well as other incentives, for nurses, midwives and other health team members, to ensure better-performing PHC systems, thereby ensuring equitable access of PHC to all.
7. Donors allocate sufficient funds for successful implementation and evaluation of the Declaration.
8. International organisations including the World Health Organisation play a facilitative role and provide technical support in implementing necessary actions to support this Declaration.
9. A task force be created by the Global Health Workforce Alliance and/or WHO to coordinate and support the implementation of activities to support this Declaration.

We pledge to disseminate, advocate and work towards fulfilment of these recommendations by working in partnership with healthcare organisations, communities, universities, governments, non-governmental organisations and the private sector at the regional, national and international levels to strengthen Primary Health Care and accelerate achieving the Millennium Development Goals.⁵²

Appendix D | Bangkok platform for action

BANGKOK PLATFORM FOR ACTION

Healthy People for a Healthy World

June 2008

In Bangkok on 25-27th June 2008, we, more than 500 nurses, midwives, and other professionals from 35 countries across all six World Health Organization (WHO) regions, representing universities, governments, non-government organizations, and the private sector, met together at the 2008 International Conference on "Healthy People for a Healthy World".¹ The goals of this Conference were to share a vision and concrete actions to achieve the Millennium Development Goals (MDGs) through the renewal of primary health care strategies, and thereby position Nursing and Midwifery for the future.

We have agreed that nurses and midwives have a collective responsibility to act to achieve these goals through:

ADVOCATING for global social responsibility and promoting healthy people for a healthy world;

IMPLEMENTING innovative strategies to ensure an adequate, competent and motivated workforce to improve access and equity in health;

BUILDING capacity for leadership to enhance active participation in policy making at all levels;

STRENGTHENING the link between education, practice, research, and effective health policies;

ENGAGING in multidisciplinary and multisectoral partnerships;

INTREGRATING socio-cultural determinants of health in education, practice, research and policy; and

REAFFIRMING the importance of primary health care in strengthening health systems to meet population health needs.

In addition to the Chiang Mai Declaration,² we urge governments and decision makers to advance this Platform for Action by increasing resources and addressing barriers that affect the achievement of these goals. Additionally, we request that governments support the development of tools and mechanism to monitor and evaluate the progress toward these goals.

1. The 2008 International Conference entitled "Healthy People for a Healthy World" on 25-27th June 2008 at the Emerald Hotel, Bangkok, Thailand
2. The Chiang Mai Declaration Nursing and Midwifery for Primary Health Care February 2008

Appendix E | ANF Fact sheet 6 - A snapshot of nurse practitioners in Australia

FACT SHEET

6



A snapshot of nurse practitioners in Australia

Who are Nurse Practitioners?

Nurse practitioners are registered nurses with the education and extensive experience required to perform in an advanced clinical role. A nurse practitioner's scope of practice extends beyond that of the registered nurse.

Nurse practitioners were first introduced in New South Wales in 2000, and now there are about 370 around Australia.

The title of 'nurse practitioner', like those of 'registered nurse', 'enrolled nurse' and 'midwife', is protected by state and territory nursing legislation. Only those authorised by their nursing and midwifery regulatory authority (NMRA) are able to call themselves a nurse practitioner. The NMRA also determines their scope of practice.

The Australian Nursing and Midwifery Council, in consultation with nursing organisations, has developed a definition and competency standards for the nurse practitioner role. The definition says:

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice.

Australian Nursing and Midwifery Council (2006). Nurse practitioner competency standards (1st edition). Canberra: ANMC.

The Nurse Practitioner's Role

The nurse practitioner role is relatively new in Australia and there is a growing body of evidence to support its effectiveness.

The official introduction of the nurse practitioner role provides an incentive for advanced registered nurses to progress their nursing career without leaving the clinical setting.

The nurse practitioner role is designed to augment those of other providers of health and medical services. Nurse practitioners are first and foremost nurses with advanced educational preparation and experience, with authorisation to practice in an expanded nursing role. Key to their role is the nursing model of practice with an emphasis on health promotion and preventative health care.

Nurse practitioners work at an advanced level in many clinical practice settings, which include diabetes care, emergency nursing, intensive care, women's health, aged care, palliative care, paediatrics, urology, wound management, mental health nursing, rural and remote health, men's health, community health and young people's health.

The title of nurse practitioner should not be confused with that of practice nurse. A practice nurse is a registered or enrolled nurse working in a general practice setting.

See also: A Snapshot of Practice Nurses


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Appendix E | ANF Fact sheet 6 - A snapshot of nurse practitioners in Australia

FACT SHEET

6

A photograph of three female nurse practitioners smiling. The woman on the left is wearing a dark blue V-neck top and holding a clipboard. The woman in the center is wearing a white top with a stethoscope around her neck. The woman on the right is wearing a light blue top. The background is a soft, out-of-focus grey.

ImageStockphoto

A snapshot of nurse practitioners in Australia

Nurse Practitioner Role in Rural Health

A nurse practitioner's role at a rural nursing centre may include case management, district nursing, practice nursing, provision of health programs and education and accident and emergency. It may also include prescribing drugs, ordering tests and x-rays and referring to specialists.

Nurse Practitioner Role in Youth Health

A nurse practitioner's role at a children's public hospital focuses on youth health, including sexual health, drug and alcohol and mental health issues. Engagement, advocacy and assisted referral are important parts of the role.

Registered Nurse to Nurse Practitioner

Nurse practitioners begin their career as registered nurses. To become a nurse practitioner, a registered nurse must apply to their NMRA. Many registered nurses develop advanced skills in a particular clinical practice setting, for example emergency nursing or oncology nursing, and will undertake postgraduate education in their area of clinical practice. That, coupled with extensive clinical experience, may motivate them to seek authorisation as a nurse practitioner.

The requirements to become authorised as a nurse practitioner differ in each state and territory, and each applicant is individually assessed based on their presentation. Generally however, applicants will have completed a Masters degree and in some states, where required, a medication module for prescribing rights. They must be able to demonstrate extensive experience in an advanced role in their area of clinical practice. If an applicant does not have a Masters degree but can demonstrate equivalence, they may still be authorised.

A nurse practitioner's scope of practice is determined by the context in which they are authorised to practice. Generally, their scope of practice differs to that of registered nurses in that it encompasses:

- advanced clinical assessment
- initiating, interpreting and responding to diagnostic tests
- initiating and monitoring therapeutic regimes
- prescribing medicines
- initiating and receiving referrals

Number of Nurse Practitioners in each state and territory, as at April 2009

Australian Capital Territory	21
Queensland	75
New South Wales	121
Northern Territory	3
South Australia	27
Tasmania	1
Victoria	44
Western Australia	75

Reference: Australian Nurse Practitioners Association (APNA)

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Appendix F | ANF Fact sheet 7 - A snapshot of practice nurses in Australia

FACT SHEET 7




Image: Courtesy APNA

A snapshot of practice nurses in Australia

Who are Practice Nurses?

Practice nurses are qualified registered or enrolled nurses¹ who deliver primary health care in a general practice setting. The environment in which they work is often unpredictable and involves caring for a broad group of people from diverse backgrounds and at all stages of life.

The Practice Nurse's Role

The practice nurse plays a pivotal role in health promotion, health maintenance and prevention of illness by providing care, information and education to individuals and the community.

While the role of the practice nurse varies according to the type of patients they see and the general practice setting in which they work, the practice nurse works in both a clinical and managerial capacity. This means practice nurses must work collaboratively with others, both within the practice and in the broader community.

Practice nursing is a relatively new area of clinical practice in Australia. A combination of factors such as a greater focus on health promotion and chronic disease management, general practitioner workforce shortages and an ageing population have seen the role of practice nurses expand and develop.

In 2005 there were approximately 5,000 practice nurses employed in doctor's rooms² and more than half (57%) of general practitioners were reported to employ a practice nurse. Anecdotally that figure has now risen considerably to around 8,000 in 2007³. Practice nurses are now employed in nearly 60% of Australia's general practices⁴.

The role of nurses in general practice includes, but is not limited to, the following:⁵

Clinical nursing services:

- triage and patient assessment
- clinical patient care, e.g. wound care
- diagnostic services
- clinical data management.

Health promotion and chronic disease management

- health screening
- immunisation
- health check reminders, e.g. pap smear reminders
- patient education
- outreach services, e.g. visiting elderly patients unable to visit practice
- acute and chronic disease management, e.g. diabetes and asthma management

Coordinating patient services:

- working with GPs to plan and manage patient care
- liaising with allied health and community care services
- coordinating delivery of health care services
- ensuring continuity of care
- facilitating effective communication between patients and health care providers
- patient advocacy.

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Appendix F | ANF Fact sheet 7 - A snapshot of practice nurses in Australia



A snapshot of practice nurses in Australia

Promoting patient, carer and community well being:

- providing education and health information
- delivering specific programs
- engaging in community development
- educating about self care.

Managing clinical standards and legislative requirements:

- infection control and sterilisation
- monitoring incidence of infectious disease
- records management
- occupational health and safety
- participating in accreditation processes
- maintaining medical supplies.

Managing clinical standards and legislative requirements:

- infection control and sterilisation
- monitoring incidence of infectious disease
- records management
- occupational health and safety
- participating in accreditation processes
- maintaining medical supplies.

Management of human and material resources:

- optimising the use of professional resources
- building the practice base
- building practice capacity to adapt to change
- maximising financial efficiency.

As regulated health professionals, registered nurses are not 'supervised' nor do they provide care 'for and on behalf of' any other health care professional. Nurses provide care in collaboration with general practitioners and other health care providers, focusing on positive outcomes for all people.

Where enrolled nurses work in general practice they must be supervised, directly or indirectly by a registered nurse.

Practice nurses should not be confused with nurse practitioners. 'Nurse Practitioner' is a title protected by state and territory nursing legislation.

See also: A Snapshot of Nurse Practitioners.

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Endnotes

1. Two of the papers from the WHO *Now More than Ever* project referred to extensively for this paper have not yet been published but are nearing publication and have kindly been made available by their authors Jane Salvage and Mary Chiarella.
2. National Privacy Principles (NPPs) are outlined in the Privacy Act 1988 (Cth) (the Privacy Act) apply to organisations not bound by a privacy code approved by the Privacy Commissioner. The NPPs aim to ensure that organisations that hold information about people handle that information responsibly. They also give people some control over the way information about them is handled.
3. For the purposes of this paper, the use of the term 'registered nurse' includes 'enrolled' nurses.
4. Faith community nursing is an innovative model that developed in South Australia in the late 1990's to provide accessible, sustainable and holistic health promotion, illness prevention and disease self management within the context of a faith community and the cultural or geographic community they serve. Faith community nurses provide psycho-social, cultural, spiritual, emotional and physical care and support to people with the support of volunteers from that faith community.

Nursing and midwifery organisations supporting the primary health care consensus view



Victorian Association of
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