Submission by the Australian Nursing and Midwifery Federation

Australian Government Department of Health and Aged Care Consultation on expanding the list of health professionals eligible for risk equalisation of private health insurance benefits under chronic disease management programs

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 326,000 nurses, midwives, and carers across the country.

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

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

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF appreciates the opportunity to provide feedback to the Australian Government Department of Health and Aged Care for the public consultation on expanding the list of health professionals eligible for risk equalisation of private health insurance (PHI) benefits under chronic disease management programs (CDMP).

The ANMF supports in principle the addition of nurses to the list of health practitioners eligible for risk equalisation of PHI benefits under CDMPs but does recommend terminology be amended to align with the *Health Practitioner Regulation National Law Act (2009)* (the National Law) and to support delegation pathways for nurses.

The ANMF offers the following feedback in response to the consultation questions.

Consultation questions:

1. **Do you agree that practice nurses, mental health nurses and/or nurse practitioners should be added to the list of health professionals eligible for benefits under chronic disease management programs?**

   The ANMF supports in principle the proposal outlined in the consultation paper and acknowledges this will lead to more secure employment for nurse practitioners working in private health systems. There is concern however about the use of inaccurate terminology relating to nursing titles as well as the risk of a two-tier health system that further excludes many from accessing care.

   On page two of the consultation paper a list of health providers is proposed for inclusion in the list of health professionals under Rule 12(2) of the PHI Business Rules, including the terms practice nurse and mental health nurse. Neither term is a protected title under the Health Practitioner Regulation National Law Act (2009) (the National Law) and creates ambiguity, misinformation and should be omitted. Further, these titles do not support delegation pathways. For example, enrolled nurses must work under the supervision and delegation of a registered nurse and cannot be supervised by a health practitioner from another discipline. To ensure the correct delegation pathways in nursing are applied, it must be clear to which protected title is being referred.

   According to Division 10, Subdivision 1 of the National Law, protected titles for nursing include registered nurse, nurse practitioner and enrolled nurse. It follows that these are the titles that should be used in the consultation paper and in subsequent documents relating to this issue to ensure they align with the terminology and protected titles in the National Law.

   The ANMF would suggest revising the use of the term patient and suggest using the term person. Chronic disease implies a long-term condition with which people learn to live. Referring to those with chronic conditions as patients results in negative labelling and the development and reproduction of power constructs that can result in learned helplessness

and stigma. Therapeutic relationships between health practitioners and people with chronic disease must be built on trust and respect and facilitate informed decision making, self-determination, independence and person-centred care.

2. **What is the process for identifying a patient to participate in a chronic disease management program (CDMP)?**

Currently a general practitioner (GP) identifies a person suitable to participate in a chronic disease management program (CDMP). Registered nurses and nurse practitioners are regulated, highly educated and qualified to provide CDMP plans and work with people who have chronic conditions. The ANMF supports expanding this element of case management to nurse practitioners and appropriately qualified registered nurses whose scope of practice includes primary and/or mental health care.

Access to CDMPs must be available to all people living with chronic health conditions regardless of whether they have private health insurance (PHI) or not. The use of PHI to provide care to people with chronic conditions must be viewed as a way of expanding access to primary care for all, not as a way of controlling care or creating a two-tier system based on profit creation.

Access to any health program must be determined based on consultation with the person and the health practitioner's assessment and the triaging of health needs. Given workforce shortages, proposed changes must not result in health practitioners triaging people according to their level of PHI rather than their need for health services based on a holistic assessment. Access to PHI funding should assist in the provision of universal healthcare by injecting funds into the public health system through block funding models, where public funds can be directed where most needed not redirecting funding to private organisations.

3. **How is it determined which health care professionals are eligible under insurer CDMP framework?**

   Health care practitioners who possess the required education and associated knowledge, skill, experience, and authority, should be included on the list of health professionals eligible for risk equalisation of private health insurance benefits under the insurer CDMP framework. Nurse practitioners and registered nurses working to their scope of practice in the primary health care setting are ideally placed to undertake CDMP plans, including allocation, monitoring and evaluation.

4. **What information is considered in developing the written plan?**

   Holistic assessment of the person with a chronic condition is essential to ensure an understanding of the social determinants of health and their impact on the person and their plan of care. Health practitioners should be working with the person to co-design and monitor the plan. Identifying and coordinating members of the multidisciplinary team involved in the care of the person requiring care is an essential component of the CDMP role, including the communication pathways that allow safe transitions of care across settings. The person managing the CDMP should be accountable and responsible for providing and collating ongoing monitoring and evaluation of the CDMP and linking actions to outcomes.

5. **What is the process to ensure the person is provided with a copy of the plan and their consent to the plan is obtained?**

   There should be no CDMP without the person receiving care's giving informed consent. Any practitioner involved in the person's care, will ideally have access to the CDMP and it is the role of the primary health practitioner coordinating care to ensure informed consent is given by the person accessing care before sharing the CDMP with other health practitioners. Sharing the CDMP may be facilitated through platforms such as My Health Record.

6. **How does coordination, monitoring, review of the plan, and provision of relevant services occur?**

   This is a role for the primary care practitioner, assisted by technology such as My Health Record and newer platforms as they emerge. Nurse practitioners and registered nurses working in primary health care settings are well qualified to undertake this role or contribute to the existing CDMP plan.

7. **Are there any other aspects of chronic disease management programs which should be considered?**

   The COVID-19 pandemic highlighted and exacerbated significant gaps in mental health service provision in both the public and private sectors. Public mental health services are typically geared towards acute care episodes. The shift away from publicly funded chronic mental health disease management started with systematic de-institutionalisation of chronic mental health services in the 1990s and continues to this day presenting issues with access and ongoing care. The burgeoning morbidity rates for mental illness, coupled with historic underfunding of the public mental health sector, are factors contributing to the intense pressure faced by public mental health services to discharge people with chronic mental health conditions into the private health sector (for example, GPs, private psychiatrists, and private psychologists) to meet the demand for acute/crisis mental health service delivery.

   The burden of care for chronic mental health disease management therefore sits largely with the private sector which raises significant issues of access and equity where those most in need are often least able to get help due to a range of socioeconomic factors. Although cautious about making sweeping generalisations about private health services, they do tend to be profit- and volume-driven, and therefore changes to the provision of private health services must manage the fine line between offering greater choice and over-servicing. There also needs to be consideration of how the public sector can meet demand for acute and chronic mental health services rather than shifting risk and funding to the

private sector.

The ANMF recognises that such change has the potential to make private mental health provision by nurse practitioners and registered nurses a more affordable and attractive option for the community, with the benefit of de-stigmatising and normalising mental health care in general.

8. **Any other feedback, including additional measures or proposals to address the issues outlined in the consultation paper.**

The ANMF emphasise that the intention and goal of measures to expand the list of eligible health practitioners should be driven by expanding choice but must still be based on the triaging of need regardless of PHI status. The private health sector does not increase access to health services for most people. It must not be viewed or positioned as a necessary part of the overall health care system, nor as a substitute for high quality public health services for all.

Also for consideration is the number of health practitioners available to provide services. and the risk that they will be drawn from the public sector into the private sector, depriving those people without PHI of nurse practitioner and registered nurse expertise. The ANMF suggests that governments must consider how best to support nurse practitioners and registered nurses who work with people who do not hold PHI so they can continue to provide universal CDMP to all groups, not a select few based on socioeconomic circumstances.

Conclusion

Thank you for this opportunity to provide feedback to the Australian Government Department of Health and Aged Care for the public consultation on expanding the list of health professionals eligible for risk equalisation of private health insurance benefits under chronic disease management programs.

The ANMF supports the addition of nurse practitioners and registered nurses to the list of health practitioners eligible for risk equalisation of private health insurance benefits under CDMP. Such changes must be based on expanding access to health care services for people with chronic disease through the injection of funding from PHI into the public system and avoiding a two-tier health system that effectively reduces access by people with chronic disease. Reducing access to CDMPs may occur overtly or covertly, either by directly triaging people based on their PHI status rather health needs or indirectly through the migration of health practitioners from the public to the private health system, resulting in less practitioners available to work with those who do not hold PHI and subjecting the existing public health workforce to additional strain. Governments need to consider these aspects in relation to the principles of access to universal health care.