

Australian Nursing Federation (Victorian Branch) Submission to the Inquiry into Primary Health and Aged Care Service Measures – Victoria

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Australian Nursing Federation (Victorian Branch)
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The logo for the Australian Nursing Federation (ANF) is located in the bottom left corner. It consists of the letters 'ANF' in a white, serif font, set against a dark blue square background.

ANF

Opening Statement (1)

- * The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.
- * The ANF (Victorian Branch) represents in excess of 61,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations in both the public and private health and aged care sectors.
- * The core business for the ANF is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery.
- * The ANF Victorian Branch is also a registered training organisation and contributes to vocational education and training of enrolled nurses, and professional development for registered and enrolled nurses and registered midwives.
- * The ANF (Victorian Branch) has members that are employed in a range of **community health services** in Victoria, including **primary health care and aged care** programs like aged care assessment teams, primary health community midwifery and nursing programs, Home and Community Care (HACC), mental health assessment, treatment and rehabilitation programs, school and dental health programs as well as practice nurses and the Hospital Admission Risk Program (HARP).

Opening Statement (2)

- * The ANF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.
- * The ANF (Victorian Branch) is pleased to provide comment to the Victorian Standing Committee on Economy and Infrastructure inquiry into primary health and aged care service measures.
- * The ANF (Victorian Branch) acknowledges the inquiry is intended to have two parts;
 1. Primary Care treatments, data collection and
 2. Whether there should be reporting of quality of care measures for aged care facilities.
- * The ANF (Victorian Branch) forms the view that any inquiry by the Standing Committee on Economy and Infrastructure – Reference Committee must put the interests of all Victorians at the forefront of any proposed reform and that in so doing ensures it does not make recommendations that will result in any extra burden in data collection to health professionals, including registered nurses and midwives, or enrolled nurses. Any recommendations made by the Committee must be fully funded and ensure the need for any additional or amended services and/or service delivery is fully resourced and not linked to productivity funding increases or decreases as the case may be.

Opening Statement (3)

- * ANF acknowledges the Victorian Government may have little detail of an individual's medical history prior to them presenting at a state operated health service for treatment. For this reason, we understand previous state governments have committed resources to the development of electronic health records across a number of public hospitals. The complexity with both the soft and hardware technology is that some of the operating systems are not capable of interfacing with data from systems outside of the primary source of data collection. Moreover, we understand that sharing of electronic health records is the major brief of the National e-Health Transition Authority (NEHTA) and the major reason there is a Commonwealth Government commitment to introduce the Personally Controlled Electronic Health Record (PCEHR) as a secure, electronic record of an individual's medical history, that will be stored and shared in a network of connected systems.
- * The Commonwealth Government has already invested \$466.7 million in the first release of the PCEHR System. The aim of the PCEHR will be to bring key health information from a number of different systems together and present it in a single view.
- * <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nehta~nehta-1> Accessed 17.8.11

Opening Statement (4)

- * The ANF (Victorian Branch) is supportive of the notion of the Victorian Department of Health having a clear picture of how consumers are:
 - a) moving through Primary and Aged Care services;
 - b) having access to robust data to ensure better planning of service delivery; and
 - c) having access to meaningful data on access and equity and service locality where there is a demand.
- The notion of developing a standardised classification system that spans the breadth of both primary care and aged care is complex.
- Consideration of the practicalities of the development of such a system will require a lot of resources and a financial commitment by the state government.
- Mandating such a concept in Victoria may require a large financial outlay to bring existing classification and coding systems into line - at a time when the National e-health Transition Authority NEHTA is already doing a large part of this work. It would be advantageous that any such system be agreed at a National level to allow for the use of comparative data being available.

Acquiring Data and Data Ownership & Privacy Issues

- * The Health Records Act 2001 (Victoria) is regulated by the Victorian Health Services Commissioner and protects health information handled by the Victorian public and private sectors. *Health information* includes information about the physical, mental or psychological health of an individual, and can include personal information collected in providing an individual with a health service.
- * The Privacy Act 1988 (Commonwealth) is regulated by the Australian Privacy Commissioner and covers the handling of *personal information* (including health information) by Federal government organisations, credit reporting organisations and parts of the private sector.
- * The right to privacy must be considered by all Victorian government organisations. Victorian government organisations are obligated to comply with the Charter of Human Rights and Responsibilities Act 2006 and act in a way that protects human rights and privacy.
- * The protection of an individual's privacy is one of the key priorities leading up to the widespread adoption of data collection through e-Health, e-Records and the PCEHR in Australia. Privacy compliance is a fundamental principle the Standing Committee needs to consider before it makes recommendations for the adoption of any reform to existing state based data collection systems or the development of new systems. State Government must be mindful of meeting their legal obligations and community expectations in relation of consumer privacy.
- * <http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/privacy-laws> Accessed 17.8.11

Should Australia mandate the provision of information in the reasons people receive primary health care treatments – i.e. epidemiological coding according to the international classification of Primary Health Care or similar.

- * The Australian government is preparing to establish a national data base in relation to people receiving primary health services and treatment in association with the implementation of the roll out of the national e-health initiative, therefore this move would seem to be a duplication of service provision and an unnecessary financial burden to the State.
- * It would seem more appropriate and logical to the ANF that the State based services are able to contribute to and access both State and National data.
- * In relation to the use of the term “mandate”, it is not clear to us whether “mandate” is to mean legislated and therefore enforceable and be associated with penalties where the mandate is breached. The ANF would not support a penalty system for nurses/midwives if they are employed in services that are not resourced
- * Should the concept, as proposed be adopted, consideration must be given to:
 - i. how epidemiological coding could be applied and contextualised to the Victorian health care sector;
 - ii. ensure that it is fully funded so there is no additional cost burden to already finite services and the time it takes to input data is fully realised, resourced and funded.

Australia should mandate the waiting times and lists for primary care services.

- * Theoretically, this is a reasonable method to ascertain whether service provision is meeting demand expectations. However ANF is not supportive of a system whereby health professionals/organisations may be penalised should wait times blow out from any mandated predetermined and recommended wait time. In Victoria there has been a range of problems emerge when this methodology has been applied to Victorian public sector emergency departments, especially where health services are penalised for not meeting their mandated throughput targets.
- * Similarly, wait lists may be an effective measure of the time a consumer waits once placed on a list for a service and actually receiving the service.
- * ANF is not supportive of a system that only provides care based upon only one medical condition of the consumer requiring care when they may require coordinated care for both acute and chronic conditions as well as care for restorative health.
- * Individuals may have varying medical histories and co-morbidities that result in longer treatment times once seen by a primary health service. These new or existing co-morbidities may blow out waiting times for the next consumer waiting to be seen.
- * Health care consumers have different outcome measures and cannot be treated as though they are all the same and will take the same amount of time to be seen and treated by a primary health service. Specifically, individuals aside from having varying co-morbidities may vary in age and gender, nationality and culture and will have differing needs based on access to services and their locality, whether metropolitan, regional or rural.
- * Therefore this data collection may be flawed and consequently subjective.
- * In relation to the use of the term “mandate”, it is not clear to us whether “mandate” is to mean legislated and therefore enforceable and be associated with penalties where the mandate is breached, this requires further clarification.

Australia should mandate the requirement for provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in primary health care settings, appropriate treatments for asthma in those settings and so on. (1)

- * The ANF (Victorian Branch) is not supportive of this proposal, as there is not a defined objective means to describe what is meant by the term “appropriate treatment”. There may be many treatments deemed as appropriate but due to funding issues or accessibility are just not available.
- * We are of the view that no health professional is in the business of initiating “inappropriate treatment”.
- * All primary and aged care is planned, implemented and evaluated based on the health professionals’ educational preparation, clinical judgment, professional knowledge and skill, taking into consideration the treating consumers healthcare history, their co-morbidities, current condition, diagnosis, prognosis, compliance ability, mental health, age, gender, nationality, cultural beliefs and support mechanisms all play a role in the treating health professionals choice of care.
- * It may be more appropriate to consider development or review of existing guidelines in relation to “appropriate treatment” for all patients with specific disease/conditions and determine if they are being met and if not why not.

Australia should mandate the requirement for provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in primary health care settings, appropriate treatments for asthma in those settings and so on. (2)

- * To single out diabetes and asthma as the key performance indicators to implement outcome measures is not supported.
- * There are many other primary and aged care outcomes that may make such data collection prohibitive for example:
 - * Whether all data will be only collected by health professionals;
 - * Access to IT technology and safe and secure computer systems;
 - * Consumer consent;
 - * Attraction of health professionals, including nurses and midwives to want to work in the primary and aged care sector – ensuring competitive wages.
- * This information is likely to be available via the national e-health service in the future.
- * In relation to the use of the term “mandate”, it is not clear to us whether “mandate” is to mean legislated and therefore enforceable and be associated with penalties where the mandate is breached, this requires further clarification.

Conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of our primary health care system.

- * The terminology used in relation to what is meant by 'surrogate' is confusing. The Australian Concise Oxford Dictionary defines surrogate as, "A substitute, esp. for a person in a specific role of office". This definition in all its connotations usually refers to a person.
- * There are medical conditions that lead to a consumer of a primary or aged care service requiring hospitalisation when acute onset or an exacerbation of a condition occurs. Therefore to consider a condition as preventable without consideration of additional factors, and relying on this as an indicator of the adequacy of the primary health care system is unfair.
- * In circumstances where people are consumers of primary health services, health professionals employed within such services may know their clients well enough to identify changes to their condition and rescue them/intervene early to prevent or reduce the risk of hospitalisation. However, not all services are the same particularly in relation to operational budgets, resources, skill mix and accessibility to ensure the consumer can access the service /health professional they need on every visit.
- * ANF supports a care system that has mandated nurse to patient ratios that provide for the staffing and skill mix of a service to be appropriate to the expected health care condition and care needs of the consumer.
- * We are broadly supportive of team based primary health care; nonetheless nurses must be recognised for the contribution they make to quality care and measurable outcomes for consumers.
- * We know where the numbers of registered nurses are available in residential aged care services to plan, implement and evaluate care outcomes, nurses are available to 'rescue' residents and therefore avoid hospitalisation. This rationale therefore must apply to all primary care and aged care measurement settings as well.
- * For example, Professor Linda Aiken's research on the role of the nurse on patient mortality and the adverse outcomes for consumers of the health system when there are not adequate numbers of nurses within the skill mix to prevent adverse patient outcomes.
- * Within the Australian health care context, there are a number of factors that need to be considered in the preventative health care space, like literacy, numeracy, cognition, socio economic issues, culture, support and the home or aged care environment that already exist.
- * The Australian Concise Oxford Dictionary. [2006]. 4th ed. Oxford University Press. South Melbourne. p. 1439

Actual rates of provision of residential aged care for each community should be provided, as opposed to bed ratios.

- * ANF is in support of this data being available and the Commonwealth Department of Health and Ageing would be best placed to collect it in accordance with its allocated aged care beds and community care places in a locality.
- * The aged care sector is already highly regulated and a vast range of data is already collected. To apply another reporting layer would be detrimental rather than beneficial.
- * The Aged Care Standards and Accreditation Agency powers should be expanded to implement and monitor systems in community aged care and aged care packages as well as residential aged care.
- * ANF is confused as to whether the term “ratios” is to mean “commonwealth allocated residential aged care beds”, rather than “ratios”? We understand that Commonwealth government publishes allocated aged care bed numbers by locality already.

Comparable rates of community care alternatives should be provided for these communities.

- * Does the term “alternatives”, mean Commonwealth allocated community aged care packages, rather than admission to a bed in a residential aged care home?
- * The term ‘alternatives’ must be defined as ‘Alternative’ to what?
- * We are unclear as to whether this point is to mean the take up of community aged care packages, in a community rather than an older person being assessed for residential aged care and admitted to a nursing home?
- * If it is to mean the latter, this information is currently available on the Commonwealth Department of Health and Ageing webpages and we are unclear why the State would seek to recaptured the data?

Quality criteria for residential aged care across a community and for each individual setting should be more clearly available and provided.


- * This requires a definition of what the expected 'criteria' for quality will be. The Aged Care Standards and Accreditation Agency has currently 44 standards that aged care homes are benchmarked against on quality outcomes for residents. The 44 Standards are currently under review by the Department of Health and Ageing.
- * There may be a rationale for such criterion to be applied to community aged care and primary health care services to benchmark best practice and quality outcomes for consumers and this information should be available to all consumers in order to make informed choices about services. Is the intention to have a system like the "My school" website to compare and contrast services?
- * Will the State fund and resource such an initiative over and above the Commonwealth funded services?
- * Who will the information be provided to? Consumers, the services themselves or to government to evaluate the need for additional services or to reduce services?
- * Will this be part of the Commonwealth "Aged Care Front End" and "Aged Care Gateway" and will it attract Commonwealth funding to enable the State to pay for implementation?
- * ANF cautions that this may result in a highlighted deficit in services and service delivery in some poorer socio-economic localities and regions. While this is may be an appropriate approach, it will only work if the Government is in a position to improve the current situation/service delivery.

Potentially unnecessary or avoidable hospitalisations of patients in residential aged care should be used as a surrogate indicator for poor care in these settings.

- * This is subjective as it may not be a qualified health professional making the decision to transfer a person from a primary, community or residential aged care service to an acute hospital for urgent medical/nursing care.
- * Factors like the skill mix of the staff in a residential aged care home is an important factor in the decision making process to transfer a resident to a hospital.
- * ANF supports adequate numbers of mandated nurse patient ratios in all aged care services to ensure all potentially unnecessary or clearly avoidable transfers to hospital are circumvented, however all health professionals have a duty of care to their clients to act in the best interests of the person in their care. If a health professional (Nurse Practitioner, Advanced Practice Nurse, or Registered Nurse) has made a professional judgment to transfer a person to hospital, then it is not unnecessary, rather a decision made in light of the skill mix and support in the context of best care outcome for the person/patient/client that the decision is based on.
- * Other support mechanisms like the availability of diagnostic service (X-ray, pathology) are also fundamental in the decision making process to send a person to hospital.
- * These issues may be better addressed by ensuring primary health services have access to mobile X-ray equipment and qualified personnel to operate such equipment and arrangements with GP's for rapid diagnostic orders and capability.
- * Increase in funding and initiatives for more Nurse Practitioners and Advanced Practice Nurses is one way to address this issue.
- * Ensure there are specialist and generalist registered nurses in all services to coordinate such services and minimise unnecessary hospitalisation, rather optimise services to maintain people in the environment they choose. i.e. Residential or home care.

Current Measurement and Data Collection

- * Information in a PCEHR will be able to be accessed by consumers and their authorised healthcare providers.
- * Once this information is available, individuals and healthcare providers will be positioned to make better decisions about an individual's healthcare and treatment options and advice.
- * Over time it is envisaged that consumers will be able to contribute to their own information and add to the recorded information stored in the PCEHR.
- * The PCEHR will not hold all the information held in their treating doctor's records but will complement it by highlighting key information.
- * The beauty of this system is that in the future, as the PCEHR becomes more widely available, consumers will be able to access their own health information anytime it is needed and from anywhere in Australia.
- * The Personally Controlled Electronic Health Record (PCEHR) will greatly enhance both the quality and the timeliness of available healthcare information, delivering substantial benefits to both consumers and their healthcare provider and the healthcare system as a whole.

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- * The ANF (Victorian Branch) suggests that the Standing Committee recommend Victorian primary health care and aged care services utilise this system to report on the measurement of primary health and aged care services and outcomes, rather than introduce additional and potentially fiscally burdensome infrastructure.

Benefits of Measuring Outcomes

- * The ANF (Victorian Branch) understands a large portion of this work fits in with the brief of the NEHTA roll out of e-health under the auspice of *Clinical Terminology*.
- * NEHTA define clinical terminology as a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Clinical terminology covers complex concepts such as diseases, operations, treatments and medicines. Furthermore, the National Clinical Terminology and Information Service (NCTIS) within NEHTA is responsible for managing, developing and distributing SNOMED CT® Australian release and the Australians Medicine Terminology (AMT) in Australia. This responsibility extends to licensing SNOMED CT on behalf of the International Health Terminology Standards Development Organisation (IHTSDO®). SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms) is an internationally preeminent clinical terminology and has been identified as the preferred national terminology for Australia, endorsed by the Australian, State and Territory governments. If Victoria was to implement another system, or layer of reporting, consideration must be given to:
 - i. Why we need to develop another system, when one has already been developed;
 - ii. Additional costs to install or upgrade existing systems, or to develop and implement another system;
 - iii. Who pays;
 - iv. Potentially duplicating services;
 - v. Creating additional work for health professionals that may be accountable to enter data;
 - vi. Over regulation of the industry.

* <http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-terminology> Accessed 16.8.11

* SNOMED CT® and IHTSDO® are registered trademarks of the International Health Terminology Standards Development Organisation.

* <http://www.nehta.gov.au/> Accessed 16.8.11

Where the Committee considers benefits

Benefits

- A. Health services will have standardised data that will allow for uniform planning and reporting and ultimately addressing determinants of health and provide greater equity for consumers.
- B. Funding can be tied to performance improvements
- C. Transparent public reporting of data to users and the community for both service and system level.
- D. It will allow for accurate intervention and appropriate regulatory changes.

ANF (Victorian Branch) Response

- A. Supported
- B. Not supported. ANF is yet to find primary health or aged care services that nurses are not already working to capacity. We remain unclear as to what additional productivity measures can be requested of nurses in these services when they are already performing within the constraints of their services budgets and throughput targets.
- C. Supported
- D. Not supported, as there is no evidence that this will occur.

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