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Promoting Advanced Practice Nursing in Health Service: Phase 1, Paper 1

Health of the Health System
A discussion paper

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Introduction

The health care system is Australia's largest industry. More people are employed in health care and social assistance than any other industry.[1] It is a very large and growing component of total government spending.[2]

Despite increasing expenditure, Australia's health service is struggling to meet health service and health care demands. The Australian population is ageing, resulting in an increase in complex and chronic illness, and higher demand for aged care services. In addition, and despite many and diverse initiatives, the health of Aboriginal and Torres Strait Islander populations has not kept pace with the improved health and life expectancy that other Australians enjoy.[2]

Another complexity is that the Australian health industry is not a single system. Health services are a complicated mix of public and private funding and service provision, and commonwealth and state and territory responsibilities.[3] There is no one system, rather there is an intricate labyrinth with all levels of government sharing responsibility for health but having different roles, including funding, policy development, regulation and service delivery.[4]

Hence, Australia's health industry is large, labour intensive, expensive, complex and struggling in its delivery of care and service to the population.

This paper is a discussion of the interface between an entrenched and struggling health system and the health service requirements and concerns of health care consumer populations. The experience of health care at the individual and population levels will be examined with analysis of factors that influence equity and accessibility of health care; choice and appropriateness of providers; and differing contexts of care. The paper focuses on current and emerging strengths and weakness of our system.

The aim of this paper is to stimulate an informed debate on the need for new health service models. These are approaches that have the capacity to provide effective patient-focussed care and systems that are genuinely multidisciplinary: approaches where medical, nursing and other health professionals are enabled to practice to their professional strengths and their full potential.

The language of health systems

Every industry has its own unique language, a terminology set that is shared by the providers and the customers of that industry. The language of the health industry is complex, variable and political. Patients, and many health professionals, do not necessarily understand the nuances of terminology and how language can shape policy and influence debate. There are many terms used in health care that are unfamiliar to the public and are used inconsistently by health care staff. One very important example is the use of the phrase 'health care'. In much public discussion, both written and verbal, the terms 'medical care' and 'health care' are used interchangeably, or medical care is used when health care is meant. John Last, public health physician and epidemiologist, defined health care as:

> Services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore health. Health care is not limited to medical care, [the latter] implies therapeutic action by or under the supervision of a physician. The term [health care] is sometimes extended to include self-care.[5 p82]

This is not simply a matter of semantics. Use of the term 'medical' interchangeably with or instead of 'health' limits the debate to consideration of specific interventions often targeted at one bodily area or function. Medical care is primarily focused on treatment and cure and assumes that the health professional is in charge, and that she or he is a medical practitioner. Importantly, this limits the potential for patient-led or patient-focussed care; for preventative health initiatives; for genuine multidisciplinary care and for consideration of broader factors that affect the health of populations.

There is similar confusion and interchangeable use when discussing 'primary care' and 'primary health care' (PHC). The difference was first brought to world attention at the 1978 International Conference on Primary Health Care. A Declaration was agreed upon that redefined health as more than an absence of illness and as an international human right [6].

The Declaration raised international awareness of determinants of health, describing health status as being influenced by access to education, safe housing, clean water and other social and economic factors not directly related to health care. It argued for PHC that 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly'.[6 p2] It is particularly relevant here because the Declaration states that:

> Primary health care … relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers … suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.[6 p2]

This is in contrast to primary care which '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'.[7] The phrase 'primary care' is used as a context of care as well, being the first level of contact for most patients and where general practitioners work.[7]

Finally, several terms are used when referring to individuals who access health care. For consistency, we use the terms 'patient' or 'client' when referring to an individual and use consumer when citing or paraphrasing external sources employing that term. Population is used when referring to groups with similar characteristics. The latter facilitates understanding of the concept of population health.[1]

Precision of terminology in health care reduces confusion, ensures effective communication and promotes optimal health care.

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[1] Population health is defined as 'the health of the population, measured by health status indicators; it is influenced by physical, biological, social, and economic factors in the environment, by personal health behaviour, health care services, etc.' [5, p137-8]

The complexity of the health system

All Australians have access to detailed information about the state of their health and health system. The Australian Institute of Health and Welfare releases a biennial report on the country's health, providing evidence to facilitate informed decision-making about health services and health programs. The latest report tells us that, while the health status of some Australians is amongst the best in the world, health outcomes are not equal for all.[2]

Aboriginal and Torres Strait Islander populations continue to have much lower life expectancy and higher rates of ill health than other Australians.[2] Nationally, access to health care is variable, especially for rural and remote populations.[2] The increasing prevalence of chronic and complex conditions, and an ageing population, is stretching financial and workforce resources. Best practice health service requirements are *not* being achieved consistently. These requirements include hospitalisation as a last resort; high-quality community-based health services for all; and good communication with seamless transition between acute and primary care services.

The reality is a complicated labyrinth with all levels of government sharing responsibility for health services but having different roles, including funding, policy development, regulation and service delivery.[8] This complexity means that attaining a cohesive system is difficult resulting in many individuals and population groups having sub-optimum health service.

The funding system is particularly complex. For much of the 20th century, Australian health care was funded primarily through private health insurance and many people worried about how they would afford health care if they became sick. The first publicly funded national universal health insurance scheme was introduced in 1974 (known as Medibank), but was changed back to a predominantly privately insured scheme within two years. In 1984 a second iteration of publicly funded national universal health cover (known as Medicare) was introduced although private health insurance has remained important. The current system is known as a mixed system because private services and funding exist parallel to the public system. Although the balance between private and public funding has shifted backwards and forwards, it has not changed substantially since the introduction of Medicare.[3]

There have been numerous minor modifications. There have been varying levels of commonwealth subsidy for private health insurance and many responses to specific health crises. These modifications attempt to fix specific problems without sufficient consideration of how changes might create new gaps elsewhere. Without other processes being refined, the potential to maximise gains in efficiency or effectiveness is lost.

Public hospital care is provided with no cost to the individual and is operated by the states and territories although funding is the joint responsibility of the states and territories and the commonwealth. Currently the commonwealth provides subsidies for some costs incurred in the private hospital system and the primary care system, through the Medicare Benefits Schedule (MBS) and some prescribed medications, through the Pharmaceutical Benefits Scheme (PBS). These benefits do not cover all costs. Preventative and other public health measures tend to be funded through particular schemes, often at state and territory level, rather than with a national systemwide perspective.[3]

Publicly funded community health services are managed differently in each jurisdiction. They provide mostly non-medical primary health care services and health promotion activities to local populations. Their service may be geographically determined or defined by a population group.[9] In the former, they are comprehensive services which might include community nursing, counselling, pathology and other clinics available at one site. Examples of programs defined by a particular population group are child health services; drug and alcohol management; and Aboriginal and Torres Strait Islander health. These targeted programs may be partially funded by commonwealth grants.

Indeed, most community health services have disparate structures and funding. For example, access to publicly funded antenatal and postnatal care is usually managed through the public hospital system. Immunisations may be privately, state and territory or commonwealth funded and the service accessed through a variety of avenues, including GPs, community health centres, and more recently pharmacies.[10] Allied health services, such as physiotherapy and podiatry may be available in community health centres, but are mostly based in private practice, sometimes co-located with general practices. Publicly funded dental services are very limited: most dental care is entirely separate from direct commonwealth or state and territory funding. Thus, the complex labyrinth of health service continues.

The Australian health care system is complicated by layers of funding, division of responsibilities, and a lack of coordination. The consequence is less effective health service delivery and a complex system for patients to navigate.

The power of fee-for-service funding

Australian rates of hospitalisation are comparatively high. Access to hospital services, apart from emergency admission, is controlled through referral to medical specialists, almost entirely managed by general practitioners (GPs). Indeed, Hall argues that GPs are the gatekeepers to the rest of the health system. [3] Almost all GPs are in private practice, delivering primary care and referral services funded through a fee-for-service system that encourages high volume and throughput rather than stability and integration of care[3].

Historically, the medical profession has been the most powerful health profession in Australia, as well as in most other countries. For example, despite successful Constitutional amendments, the medical profession blocked introduction of the Pharmaceutical Benefits Scheme (PBS) for several years from 1945 onwards, arguing that 'the [PBS] scheme was an infringement on the medical profession's freedom to prescribe medicines' and later that they 'did not support the proposed administrative and remuneration arrangements'. [8 p9]

This powerful lobbying continues today: the medical profession has a disproportionately strong influence in decisions relating to funding and delivery of health services. Current Australian fee-for-service health funding structures are a clear example of the 'almost complete commercial monopoly' that the medical profession has over health funding.[11 p23] In 2009, the Australian Nursing Federation (now the Australian Nursing and Midwifery Federation) argued that:

> 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 PHC being realised – that of transdisciplinary teamwork'.[11 p23]

Primary care in Australia is largely managed by private service providers that establish one or more general practices as for-profit businesses with about 22% of GPs being practice owners.[12] The main service provider is a GP. The patient can be charged for services up front with partial reimbursement from Medicare.

Free patient access to GPs has been improved through the process of bulk billing, where the GP bills the commonwealth directly through the MBS when treating a patient, rather than the patient paying. This billing is at the GP's discretion and results in GPs receiving a lower fee. Over 80% of GP consultations are bulk billed but this percentage varies geographically.[12] Bulk billing is higher in metropolitan areas (where GP numbers are higher) and much lower in rural and remote locations.

Universal primary health care is constrained by the way that fee-for service items are structured. The patient rarely has choice of *type* of provider, since very few general practices or community health services employ other eligible providers,[2] such as nurse practitioners. This is partly because there are very few MBS items for health services supplied by other eligible providers that can be claimed by organisations offering bulk billing or that can attract reimbursement for patients.[13, 14, 15] Where general practices provide other services such as immunisations and care planning, usually undertaken by nursing staff, the service is recorded against the GP's provider number.

The fee-for-service funding structure and primacy of general practice as gatekeepers of health service favours throughput over care coordination and limits potential for true interdisciplinary teamwork.

[2] An eligible provider is one who is eligible for a MBS provider number.

Health care equity and access

Millions of Australians have less than optimal access to the health system. These inequities are best illustrated by two population groups that are consistently reported in the biennial report 'Australia's Health'.[2] The groups are those that live in rural and remote areas and those who identify as having Aboriginal and Torres Strait Islander origin.

Rural and remote populations

Approximately 7 million people live in rural or remote Australia and age-standardised potentially avoidable death rates are up to 2.5 times higher in very remote areas when compared with major cities[2]. Reasons for differences in mortality are complex and include socio-economic factors such as lower levels of education and employment.[2] However, it is also true that access to specialist services such as cancer care or mental health services is lower. Access is limited by a lack of outreach services in many areas and by the long distances that patients need to travel to fixed provider locations such as hospitals and specialist outpatient facilities. These disparities are well documented.[2,11,16]

In addition, access to primary care is lower in rural and remote areas. Sometimes reduced primary care is explained by reference to lower GP numbers outside of metropolitan areas.[12] This presupposes that primary care and primary health care cannot be provided without medical practitioners. Nurses are most likely to be the first health professional seen by people in remote and very remote communities, both for specialist and primary care needs. Based on 2016 data[2], AIHW reports that nurses have the highest match by population density across Australia (measured by the new Geographically-adjusted Index of Relative Supply[3] used to identify areas with health workforce supply challenges). Despite this, frequently nurses practicing in rural and remote areas are prevented from working to their full scope of practice due to district, state and territory or commonwealth restrictions.[11,16]

Aboriginal and Torres Strait Islander populations

Many problems experienced by populations that live in rural and remote areas are similar to problems experienced by Aboriginal and Torres Strait Islander Australians, a large number of whom live in rural and remote locations. However, the health status of metropolitan-living Aboriginal and Torres Strait Islander populations is also, on average, lower than that of other groups.[2] Child mortality is more than double that of other Australian population groups.

Nearly half of all Aboriginal and Torres Strait Islanders have long term health conditions or disabilities that affect their ability to carry out activities of daily living, a statistic nearly twice that of non-Aboriginal and Torres Strait Islanders.[2] Simple infectious diseases, common in Aboriginal and

[3] The Geographically-adjusted Index of Relative Supply (GIRS) takes into account how hard it might be for people to access services based on the dispersion of the population, the size of the area and whether people can access services in neighbouring areas. Therefore, it is a better indicator of the relative workforce supply in an area than provider-to-population ratios on their own.[2]

Torres Strait Islander populations, have long term health sequelae if not treated. Examples are otitis media and streptococcal throat infections.

Culturally appropriate population health and PHC programs have the potential to close the gap between the health status of Aboriginal and Torres Strait Islanders and other Australians. This requires health professionals to work *with* and *for* communities rather than being part of solutions imposed from afar.[11] In a recent one-month survey period only four percent of GPs reported working partly or wholly in Aboriginal Medical Services or Aboriginal Community Controlled Health Organisations. [12] Whilst larger Aboriginal Medical Services (AMS) and Aboriginal Community Controlled Health Services (ACCHS) employ medical practitioners as well as other health professionals, most small ACCHS are without medical practitioners and rely on Aboriginal or Torres Strait Islander health workers and/or nurses to provide the bulk of primary care services, with a strong focus on prevention and health education.[17] These smaller services are likely to be in more remote locations. Reform is needed to introduce new service delivery models that promote inclusion of advanced practice nurses and nurse practitioners, thus guaranteeing that isolated populations have equitable health services.

Currently, commonwealth funding for initiatives to close the gap between Aboriginal and Torres Strait Islanders' and other Australians' health outcomes are managed through no less than four schemes.[18] Two of these provide free or reduced cost access to PBS items for Aboriginal and Torres Strait Islander populations and the other two facilitate enhanced health care access mainly for people with chronic health conditions and those needing PHC. The latter two schemes are managed through monies provided to general practices and Aboriginal and Torres Strait Islander health services. These are reimbursements that fall under the Practice Incentives Program or the Integrated Team Care Program.[18] Funding for the last has recently been transferred to Primary Health Networks (PHNs), a new initiative explained later. This fragmentation prevents health policy and service for Aboriginal and Torres Strait Islander populations being person-centred and holistic.

Health reform must address health inequity, shift the emphasis of health service from narrow curative models to holistic, person-centred models.

Challenges for health service

Health care funding tends to be focussed on acute care, rather than the community or primary care sector. Unnecessary admission to or delayed discharge from acute facilities occurs because other sectors are overloaded and/or underfunded. In particular, the elderly, and people with chronic and complex care needs, spend longer than necessary in acute hospitals.[4,8,11]

Chronic and complex care

The categorisation and distribution of chronic and complex conditions have been comprehensively described elsewhere.[2,4] The *impact* of chronic disease on health services is the focus of this discussion. Chronic and complex conditions are one of the four main causes of preventable hospitalisation[4], an important health care outcome measure that evaluates quality, safety and access to health care.[20 p11]

At present, there are few comprehensive health care models that serve this patient population. When primary health care is working effectively many people with chronic and complex care needs actively manage their health status and live independently. If provided with access to adequate information and support from a range of health professionals this population can avoid or limit hospitalisation. However, patients with chronic and complex conditions justifiably criticize the fragmented, uncoordinated, Australian health care system.[4] They may see many service providers who do not necessarily communicate with each other. A particular issue is the patient's transition between acute care and primary care not being well coordinated. All too often the consequence is preventable or prolonged hospitalisation.[20]

Healthy ageing and aged care

The challenges of health care provision for people with chronic and complex conditions overlap with those of health care provision for older people, in part because chronic disease is more common in older population groups. For society, adverse consequences of population ageing include fewer people of working age; increased health care expenditure; and increased demand for health and social care workers.[2]

Ensuring that older Australians remain healthy and independent for as long as possible is one way of mitigating these adverse social and economic consequences. Healthy ageing is enabled by preventing disease, by identifying new conditions as early as possible and by managing chronic conditions optimally, all central goals of PHC.[6,7] Many problems that diminish the potential for healthy ageing are related to limitations of current primary care services and have already been outlined.

[4] Measures those hospitalisations that may have been avoidable if the person had received appropriate primary or community-based care.[19]

A particular problem with health care for the aged occurs in residential aged care, where there may be non-existent primary care services for residents. Many GPs argue that it is not economical to visit patients in aged care facilities and they are reluctant to undertake aged care facility visits, especially after hours.[21] If residents are unable to travel to a general practice, they may be denied access to primary health care services. More importantly, early signs of acute illness may be missed. Most residential aged care facilities are staffed primarily by unqualified and overworked aged care workers, supervised by a critically low number of registered nurses.[22] Low staffing numbers, inadequate registered nurse ratios and no GP attendance on site can result in delayed diagnosis and treatment of potentially simple problems.[22,23] Once a problem is identified aged care staff may have no option but to call an ambulance to transport the resident to the emergency department.

Arguably, GPs are not the best health professional group to manage health care in aged care facilities. Nurses and the nursing model of care are central to health promotion and disease prevention in aged care. Key safety and quality indicators of residential aged care are highly nurse sensitive, such as prevention of pressure injury and skin tears.[23] There is good evidence that advanced practice nurses and nurse practitioners employed in aged care facilities reduce adverse events and prevent acute hospitalisation.[22, 24]

Health services for community and residential aged care require a collaborative service model led by advanced practice nurses and nurse practitioners.

A wave of primary care reform

Primary care is one area where there has been considerable change in an effort to address deficiencies in service provision. However, recent commonwealth interventions appear to continue the currently ineffective pattern of medical dominance of health service, despite the language of multidisciplinary team work and patient choice in statements of purpose. Two recent examples are Primary Health Networks and Health Care Homes.

Primary Health Networks

A much-heralded change in management of primary care was the introduction of Primary Health Networks (PHN)s in 2015. Prior to this, Dr John Horvath was asked to review the role and performance of Medicare Locals, a national primary care reorganisation initiated only a few years earlier by the previous commonwealth government.

In a damming report, Horvath (a medical practitioner and previous Australian Government Chief Health Officer) presented a polarised perspective, arguing that relationships with GPs had been eroded 'through Medicare Locals pursuing an operational focus centred on practice nurses and practice managers rather than engaging the GPs themselves'[25 p5]. In his recommendation Horvath asserted that:

> Any attempt to improve integration in the PHC system requires general practice to be front and centre….. the original intent of Medicare Locals was to broaden the net of professional engagement within the PHC sector, but this appears to have come at the expense of GP goodwill. This goodwill needs to be rebuilt if any future organisation is to be successful … it must be recognised that GPs are by their nature the first authoritative point of contact for PHC, they start the patient on their care pathway and remain critical to their ongoing care. [25 p10]

Most of Horvath's recommendations were taken up swiftly by the commonwealth government: in July 2015, 31 PHNs replaced the previous structure of 61 Medicare Locals. The commonwealth government justification was that fewer streamlined organisations, covering larger geographical areas, would reduce fragmentation of care[26]. However, Primary Health Networks (PHN) commission[5] rather than provide care directly, purchasing services in response to gaps and shortages.[28, 29] The language of PHNs' purpose is focussed on 'efficiency and effectiveness of medical [sic] services for patients'. [28]

The 31 PHNs are managed by 29 Boards (Western Australia has three PHNs managed by a single Board). A desktop audit of PHN Board membership was conducted in October 2018, using publicly

[5] Commissioning 'is a process of identifying population health needs, designing, and securing appropriate services'. [27 p 322]

available information listed on each PHN website at that time. One Board did not provide information on the professional background of its directors. Almost all Boards were chaired by a GP. Board membership was heavily medical practitioner dominated, with between two (2) and five (5) medical practitioners as directors on each Board.

In total, only nine (9) registered nurses were professionally identified as Board members/directors and no Board membership listed more than one registered nurse. It is estimated that, at the time of the audit, less than one third of all PHNs have the profession of nursing explicitly represented on managing Boards and total membership/directorship of nurses across all Boards is less than 4%.

This low nursing representation at the leadership and decision-making level appears to continue in Clinical Councils (committees which are required of all PHNs). Often Clinical Council membership is not clearly identified on PHN websites and, where professional background is provided, almost all are GP led. Most have consumer and allied health professional representation clearly stated but few have any identified nursing representation.

The information provided by the Commonwealth Government states that PHNs have seven (7) priority areas: mental health; Aboriginal and Torres Strait Islander health; population health; digital health; health workforce; aged care and alcohol and other drugs.[28] In PHN governance and decision-making entities, these priority areas are almost exclusively represented by medical practitioners, predominantly by GPs each with a stated special interest in a priority area.

Despite population health being a priority area, media releases at the time of the PHN launch indicated that medical treatment of patients would be emphasised rather than primary prevention or addressing underlying causes of poor health.[26] Thus, PHNs still espouse the primary care focus with disease prevention strategies focussing on the individual and many processes focused on cost containment (as described by Keleher[7]), rather than a PHC and population health focus. Evaluation of this major change to primary health funding nationally is being led by the Centre for Primary Health Care and Equity at the University of New South Wales, but there are no publicly available results to date.

Health Care Homes or Medical Homes?

The Health Care Home (HCH) model of care is another new initiative, specifically focused on addressing the challenges of chronic and complex health care.[4] The HCH initiative was recommended in a report from a commonwealth appointed Primary Health Care Advisory Group. This Advisory Group was led by Dr Steve Hambleton, past president of the Australian Medical Association and a practising GP. Advisory Group membership was stated to include people with a wide range of experience and expertise in PHC services, including allied health, pharmacy, GPs and consumer groups.[30]

The 16-member Advisory Group included only one nurse and no less than 10 medical practitioners, mostly GPs. Given that the nursing profession manages and delivers most community and home-

based health care, the inclusion of only one nurse on the Advisory Group is extraordinary. Reasons for selection were stated against each name. Stated GP expertise included economics, mental health, MBS review and Indigenous health. This last expert was not identified as a person of Aboriginal or Torres Strait Islander origin and there appeared to be no Aboriginal or Torres Strait Islander representation on the Advisory Group despite the lamentable state of health outcomes for this population group. Non-medical practitioner members were listed as having expertise in pharmacy, practice nursing, allied health, consumer representation, insurance and health administration.

There was much of promise in the Report from the Primary Health Care Advisory Group, however. It clearly identified earlier limitations of the Australian health care system, stating that 'PHC… often appears to be more a collection of separate services than a coordinated and integrated system'. [4 p12] It argued that 'recognising and funding 'care coordination' is a discrete area of care-related activity' [4 p13] and called for 'increased provider satisfaction, working to full scope of their license'.[4 p20] It noted that the preferred clinician of a patient may be a nurse practitioner. [4]

Based largely on research from the United States (US), a new model of care was proposed, called Health Care Homes. However, like the US precursors, it was and continues to be described as a 'medical home'. [4 p21] With such a descriptor, it is hard to see that this new model of care would be a truly coordinated, multidisciplinary, patient centred solution with flexible service delivery for people with chronic and complex conditions.

The Advisory Group Report clearly stated that it contained limited detail for the new model, including no calculation of establishment and continued support costs. However, a trial of Health Care Homes was established in late 2017. The trial is being organised through PHNs. Patients can access the HCH model only if their preferred practitioner is employed by, or contracted to, a general practice or ACCHS enrolled in the trial.

Despite the language of collaboration in the Advisory Group Report, the information for potential patients and for health care professionals on the commonwealth health department website is very GP focussed. Currently, health professional and patient videos start by providing a reassurance that the patient can still see their 'own' GP. The language of patient advice is about enrolling with a GP and subsequent care being shared with the wider team.[30] Theoretically, there is provision for a nurse practitioner to be the patient's 'nominated clinician'. However, this does not appear to be mentioned in current patient information. Moreover, the profile of nursing in currently available patient information about Health Care Homes is focussed on the role of the practice nurse, as a team member who may, for example, 'telephone to check progress'. [30]

As of October 2018, only 10 PHNs list any participating Health Care Home practices. With the initiative still in the establishment phase, there is no available review of effectiveness. At present, the targets and performance indicators are focussed on set-up and it is not possible to judge whether or not the initiative will be successful.

Reforms are needed to generate new models of care that are truly coordinated, multidisciplinary and patient centred: indisputable primary health care models rather than traditional primary care models.

New ways of 'doing' health

It is clear that, while there are many triggers for health service reform, the current primary care reforms simply support the status quo and do not address inequities. It is not a question of *more* health funding but rather a redistribution of funding. Redistribution to explicitly fund services provided by *all* health professionals and not just those provided by medical practitioners would promote comprehensive and coordinated care.[31]

An accessible and equitable health service will reduce demand on the hospital system; alter the balance between medical care and primary health care and promote a focus on patients and populations rather than on specific diseases.[32]

In the last decade several national reports and discussion papers have provided recommendations for new ways of improving health outcomes for Australians. These documents make important contributions to the national debate about how health care can be made more accessible to all Australians; about how health professionals can be employed to their full scope of practice; and about how expenditure on health can be most effectively acquitted. Regrettably the potential of nursing is not realised in most of these documents. Australian health service models remain overwhelming medical practitioner led, despite calls for greater multidisciplinarity, with current funding modalities not supportive of other options. Where apposite, overt inclusion of nursing models of care, with advanced practice nurses and nurse practitioners leading care, will enable both medical practitioners and nurses to deliver equitable and accessible health services and will provide greater job satisfaction for both groups.

In addition, this discussion paper begs the question about why very few nurses are selected for positions of influence and advice at commonwealth, state and territory and local level. The culture of the health service will change where there is true multidisciplinary decision making and service provision. The new generation of health professional students are being exposed to interdisciplinary learning but their experience once qualified often belies the interprofessional respect experienced in their initial education. If there are more nurses in senior leadership and advisory positions, the focus of health care will broaden from medical interventions for single conditions to holistic care; from treatment to prevention and population health; from hospital to community care; from clinician centred to patient centred care.

Governments of all levels must confront existing power structures and embrace new ways of health service provision and funding.

Conclusion

Australia has a complex combination of public, not-for-profit and private funding arrangements. Pressures on current health service models include the ageing population, workforce shortages, changed patient expectations and the rise in chronic disease prevalence. Health outcomes for most Australians are world class but there remain gross inequities in the system. Some population groups are underserved, have poor health outcomes and higher mortality. Currently, services and funding remain focussed on acute care within a medical model, despite attempts at health care reform.

These reforms have failed because modifications are piecemeal. They have failed because the rhetoric of multidisciplinary care is not translated into practice. They have failed because one health profession dominates decision-making agencies, advisory bodies and leadership groups at most levels of government.

Strategies are needed to change the balance of power in health service policy making; to promote real coordination between services; to prioritise primary health care over acute care and to promote genuine equity of access to health care for all Australians. Failure to address challenges and to make changes will result in a spiral of increased demand on health services and reduced health outcomes despite increased spending. Advanced practice nurses and nurse practitioners are an essential part of future health care reform, in terms of both service provision and leadership.

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