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The challenge of nurse innovation in the Australian context of universal health care

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Summary As nursing pushes further into the realm of primary health care in Australia, an understanding of the challenges to achieving reasonable federal funding of nursing services needs to be understood. This understanding is underpinned by a comprehensive understanding of the concept of universal health care, how the concept relates to the Australian health care context, and the resultant challenges to innovation in health care service delivery in Australia. Universal health care is a global mission and was the most recent theme for the International Council of Nurses Congress in Australia. Universal health care as a concept represents a fundamental shift from the development and funding of discrete interventions or programmes, to that of developing systems of health care. The three critical elements required are a clear definition of what is considered health care and funded for who, how the system is financed, and evaluation. Australia has a system of universal health care and all three elements are addressed. Organised medicine, a key objector to the introduction of the current approach to universal health care in Australia, soon adapted to it, and now fiercely resists change. Medico centricity poses challenges to sustainability as innovation is inhibited. This challenge is illustrated through consideration of the implementation of the financial policy that gave Nurse Practitioners access as providers and prescribers within Medicare funded services.
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Australia has a system of universal health care, and like all countries there are strengths and challenges. One of the significant challenges to universal health care in Australia has been medico centricity in design of the system. Organised medicine was one of the key interest groups in the negotiation of the system of universal health care, and as with all policy by negotiation; strong interest groups are often over represented in the vision of type of service funded and by whom. Nurse innovation is limited in the Australian medico centric funding system. The access to the Medical Benefits Scheme (the primary direct means of commonwealth health funding for primary health care services) in 2010 to enable Nurse Practitioner services to be funded at the Commonwealth level as an innovative means of promoting accessible

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quality health care is critically discussed as an example of nurse innovation.

Universal health care

The UN in 1948 passed a universal declaration of human rights in which it was stated that everyone had the right to a standard of living compatible with health and that this included health care, but also security in the event of disability (Sachs, 2012). The United Nations (UN) general assembly in 2012 refined the sentiment embodied in earlier resolutions and passed a resolution endorsing universal health care (UHC) as a key global objective (Vega, 2013). The resolution included the urging of all member states to develop systems that minimised or avoided direct payments at point of care and to develop a system for pooling risk to avoid catastrophic out of pocket costs and impoverishment. This sets the scene for development of the post Millennium Goals agenda. The major limitation of the UN goals 2000—2015 was that system development was not stated as the underpinning factor required for delivering UHC. The 2012 resolution remedied this shortfall.

Running in many ways parallel to the UN in 1948 the World Health Organisation was constituted and also promoted right to health as a human right (Sachs, 2012). In the Alma-Ata declaration the contribution of health to the goods of society of peace and security was explicitly acknowledged (World Health Organisation, 2010). In 2005 the WHO member states committed to development of financing systems to promote equity of access to health care without consequent financial hardship (World Health Organisation, 2010). The WHO statements had moved through a descriptive phase of identifying the right, to a mechanistic phase where the threat of inequity to the right was diagnosed, to finally an intervention phase where the instrument informing principle of UHC was identified (Sehgal, 2009). Both the UN and WHO are consistent with this drive towards UHC, as health is not only a fundamental human right, it is also a critical factor for global economic and social security (Evans, Marten, & Etienne, 2012; Garrison, 2013). UHC at the most fundamental level acknowledges the widely agreed on right to health care and the right to not be impoverished through the process of acquisition of the needed care through point of contact costs, and definition has been approached through these two elements, or thirdly through systems devised for financial protection (Savedoff, Ferranti, Smith, & Fan, 2012). ''Although the precise definition of universal health coverage can be debated (too broad for some, too specific for others), the fundamental underpinnings are more widely accepted'' (Latko et al., 2011, p. 2162).

The three aspects that a policy of UHC would cover are the three fundamental underpinnings of, right to health care (and what health care means and for who in that context), the financial system to enable it, and a mechanism to monitor utilisation of health care services to ensure effectiveness and equity. All three elements need to be clearly understood in the particular national context where nurses seek to introduce service innovation.

What is viewed as health care has evolved rapidly over the last two hundred years. Prior to the late 19th century and the advances in biology, and individual curative management beginning with germ theory, a population focus to health care was dominant (McKee, Balabanova, Basu, Ricciardi, & Stuckler, 2013). Following success with antibiotics and curing communicable diseases the previous vision of miasma weakened, and the focus on population health (preventive) diminished (Smith, 1982). Post World War two medicine had progressed to the point where it could be demonstrated that intervention at the individual level (curative, palliative and rehabilitative) could arrest mortality from preventable disease and make a solid return on national investment (Davis, 2001). This was the time, and conditioning element of the context, in which the UN and WHO were formed. An individual and acute episodic vision followed, or targeted vertical streams of intervention focussed on specific diseases. Attention drifted from social determinants of health, and whilst at times goals merged with streams of intervention, it has been argued that the related public health goals need to be explicitly stated (Ooms et al., 2013). UHC as a concept brings together these focusses in what is considered health, as they are in no way mutually exclusive and both must be accommodated (Garrett, Chowdhury, & Pablos-Mendez, 2009; Latko et al., 2011). UHC as essential components has preventive, curative, palliative and rehabilitative elements. In UHC, ''health policy should also remain alert to interventions outside of the health sector that can have a large effect on health outcomes'' (Sachs, 2012, p. 944). UHC embodies valuing goods and services supportive of health (can be broadly seen to include such things as sanitation, safe communities, availability of food and education) and an awareness of vulnerability of some groups to miss out (Allotey, Verghis, Alvarez-Castillo, & Reidpath, 2012).

This vulnerability of groups to get less than their share has been referred to as social stratification and is linked to poor health outcomes (Allotey, Yasin, et al., 2012). Of course the principles of UHC are entirely consistent with nursing philosophy. UHC as a principle firmly embraces equity of access to what is determined to be health care, for those considered eligible, in any particular national context (World Health Organisation, 2010). The equity of access is encapsulated in the U (universal) of UHC (Allotey, Yasin, et al., 2012). Clear definition of the what is included in that which will be covered is essential, as countries are faced with the prospect of potentially limitless need (want) and finite resources to pay for service to meet the perceived need (Baltussen, Norheim, & Johri, 2011; Shelton, 2013). This decision needs to take account of effectiveness of goods and services in meeting the countries goals and efficiency in doing so (Evans & Antunes, 2010). The decision is not clear cut and is impinged on by factors such as the need of provision of service to widely dispersed (rural or remote) populations that comes with additional cost (Baltussen et al., 2011).

How to financially cover UHC is found in the mechanism of pooled funding. ''Abundant evidence shows that raising funds through required payment is the most efficient and equitable base for increasing population coverage'' (World Health Organisation, 2010, p. V1). These funds may be raised through taxes or mobilised through mandatory premiums to insurance schemes (Savedoff et al., 2012). Pooling involves pooling of funds as well as risk, as in effect there is a redistribution of finances to cover the risk of ill health at an individual and community level from healthy to sick, and

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