Queensland Nurses & Midwives' Union

Submission to

Productivity Commission

5-year Productivity Inquiry:
The Key to Prosperity - Interim report

October 2022

106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

submission

Contents

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Productivity Commission for the opportunity to comment on the *5-year Productivity Inquiry: The Key to Prosperity - Interim report*.

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), midwives, nurse practitioners (NP) enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 67,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU.

The issues raised by the QNMU in our response to the initial call for submissions in February 2022 remain significant barriers to productivity growth in the health and aged care sectors, namely:

- The increasing privatisation of healthcare,
- The reduced role of government in public services,
- Slow uptake of nursing- and midwifery-led models of healthcare provision,
- Delayed implementation of the *Shifting the dial report* recommendations.

This submission will focus specifically on the delayed implementation of *Recommendation 2.3* from the previous Productivity Commission report *Shifting the Dial,* namely 'Reconfiguring the health care system around the principles of value-based patient-centred care, and using information and data better to inform providers, researchers, and consumers' (Productivity Commission, 2017).

Recommendations

The QNMU recommends:

- Developing a national policy of value-based healthcare.
- Establishing an Innovation Fund to support the implementation and evaluation of value-based healthcare.
- Establishing a *Health Performance Commission* to gather, analyse, and report on health services performance data and to provide evidence to feed into the framing and evaluation of future federal *Wellbeing* budgets.

On measuring healthcare productivity

Healthcare productivity has traditionally been measured by comparing the total amount of health care 'output' produced (i.e. all healthcare provided to patients) to the total amount of 'input' (staff, intermediate and capital resources) used to produce this output (Castelli et al., 2015). In Australia, such data is used to inform an activity-based funding (ABF) model, where hospitals are paid a certain price for each patient treated according to their service type, price weights, the National Efficient Price (NEP), and the level of activity as represented by the National Weighted Activity Unit (NWAU). Funding is therefore tied to the volume and the prices of services delivered (Laberge et al., 2022).

However, this method of measuring productivity needs reform. While ABF has been associated with an increase in activity, a decline in length of stay (for hospital admissions), and a reduction in the rate of growth of hospital costs (O'Reilly et al., 2012), such increases in activity volume and patient throughput has occurred without adequate outcomes measurements on the things that really matter – that is, the health outcomes of the patients.

As noted in the interim report, productivity growth is about "learning to do more with the resources we already have […] which become embodied in the things that we build and the ways that we organise and approach tasks" (Productivity Commission, 2022). This is particularly vital for the health and aged care sectors, given the post-pandemic landscape; healthcare expenditure will continue to be a significant issue in Australia off the back of an aging population, advances in healthcare technology (and associated costs) and the public's expectations of healthcare services and models of healthcare delivery (Kämäräinen et al., 2016). Changes to the healthcare sector should therefore seek to enhance and improve upon what is currently available.

The QNMU therefore expresses concern that the interim report claims that one of the challenges facing the health and aged care services sector is "a lack of competition and contestability" (Productivity Commission, 2022). While increasing competition (often because of deregulation) may support productivity growth in other sectors, this may not be the case in healthcare. In some instances, improvements in productivity have been shown to be smaller after healthcare services were transferred to a liberal market (Gaspar et al., 2019). We witnessed the chaotic response by the largely privatised United States health care system to the COVID-19 pandemic , which was not surprising given its well-known structural issues around access to care, administrative efficiency, equity, and health care outcomes (Schneider et al., 2021). The QNMU cautions against applying neoliberal reforms to the healthcare system principally because the reforms rely on a free market rather than the right to health and healthcare.

Instead, we contend that the reluctance of governments to act toward truly innovative, more effective value-based healthcare funding models is a greater impediment to accessing high quality, effective and sustainable health and aged care services.

We again urge the Productivity Commission to make a strong recommendation to move our healthcare system towards a value-based, patient-centered productivity measurement model to be able to achieve real progress in improving health service provision and improving health among the community. This was already identified in the 2016 Productivity Commission report *Shifting the dial*, however little progress has been made on a coordinated national level. We believe that setting a timeframe in which to achieve progress in this area would further provide greater impetus for governments to act.

A national policy of value-based healthcare

The case for value-based healthcare has been made (Australian College of Nursing, 2020; Haddock, 2019; Porter, 2010; Porter & Teisberg, 2006), and it has already been adopted in some states, most notably in New South Wales (NSW) beginning with the *Leading Better Value Care* initiative (NSW Health, 2021).

To avoid a fragmented, piecemeal approach to its implementation, we believe that value-based healthcare must be on the national policy agenda, beginning with an agreed upon definition of *value* by all stakeholders, including governments, healthcare providers, clinicians, and consumers (Looi et al., 2021). This agreement on a definition is vital to ensure that measurement of outcomes is consistent, accurate, and meaningful to the original purpose of value-based healthcare, that is, improving patient health outcomes through the provision of high quality patient care (Teisberg et al., 2020).

Learning lessons from jurisdictions that have already moved toward value-based healthcare systems requires consideration, particularly in the implementation and should include:

- Clear and active government involvement in policy implementation and direction in supporting healthcare providers to adopt value-based health care systems (Mjåset et al., 2020).
- Strong and proactive clinical leadership and engagement across all professions (Koff & Lyons, 2020), especially the nursing and midwifery professions which are at the forefront of patient care delivery.
- Cultural transformation and re-orientation of the whole system through the development of a value-based healthcare framework and policies to support it (Dawda et al., 2022).

Establishing an innovation fund to support value-based health care

The QNMU considers a value-based healthcare system could be fostered through the establishment of an Innovation Fund to trial and evaluate new models of funding, which would complement the current ABF model, to:

- Address current and future demand.
- Improve performance, capacity, and innovation.
- Support integrated care services between acute health, primary health, mental health, and aged and disability care.
- Provide greater access to health resources and better weight funding models to First Nations people and other disadvantaged groups to improve health outcomes.

Measurement and evaluation of productivity would be based primarily on the quality of health outcomes, as well as system and economic efficiency, patient and clinician satisfaction, and overall community wellbeing.

This could be supported through the further establishment of a transition fund to move to new funding arrangements after successful evaluation of such trials.

Measuring health productivity and performance

The QNMU considers there is also a need to better measure productivity in the health services sector and has previously raised the possibility of establishing a '*Health Performance Commission*' for the purposes of gathering, analysing, and reporting on health services performance data. This would be an overarching, independent body that would co-ordinate health data across the public, private and aged care sectors from collection to publication. It would be timely to establish an independent *Health Performance Commission* given the newly elected federal Treasurer's intent to frame future budgets in a broad wellbeing frame. Work must therefore commence on the indicators to measure success of budget initiatives from a wellbeing frame and data from an independent *Health Performance Commission* would provide an invaluable input to evaluating progress.

We envision that a *Health Performance Commission* could also have carriage over:

- Linking hospital and health data with other economic and social data to develop an evidence base for new health programs that support value-based health care.
- Facilitating greater integration and co-ordination of health care services and resources between government sectors and levels of government.
- Developing and standardising the quality of clinical performance indicators for value-based health care.

- Improving access to clinical and performance data by clinicians, boards, and departmental staff.
- Ensuring compliance with mandatory public reporting requirements across all health sectors.
- Consulting with consumers and interest groups, including unions and professional colleges, on the format, content, context, and accessibility of publication of health data to further professional and industrial development.
- Undertaking and funding ongoing research to develop standardised national nurse/midwife sensitive outcomes as important mechanisms for evaluating patient safety, including staffing numbers, patient ratios, skill-mix levels, workload monitoring, and professional satisfaction.

General comment

As the Australian healthcare system moves to align itself with trends in the wider international community toward a value-based, patient-centred system, it is vital that healthcare professionals such as nurses and midwives are included in the development, implementation, and evaluation of any proposed changes to ensure alignment with professional values and workforce sustainability.

References

Australian College of Nursing. (2020). *Value-Based Health Care through Nursing Leadership —A White Paper by ACN 2020*.

Castelli, A., Street, A., Verzulli, R., & Ward, P. (2015). Examining variations in hospital productivity in the English NHS. *Eur J Health Econ*, *16*(3), 243-254.

Dawda, P., True, A., Dickinson, H., Janamian, T., & Johnson, T. (2022). Value-based primary care in Australia: how far have we travelled?

Gaspar, K., Ikkersheim, D., & Koolman, X. (2019). Deregulation and productivity in healthcare: The introduction of provider competition in the Netherlands. *Maandblad voor Accountancy en Bedrijfseconomie*, *93*(7/8), 197–202.

Haddock, R. (2019). *Reforming for value: Opportunities for outcome-focused national health policy*. A. H. a. H. Association.

Kämäräinen, V. J., Peltokorpi, A., Torkki, P., & Tallbacka, K. (2016). Measuring healthcare productivity – from unit to system level. *International Journal of Health Care Quality Assurance*, *29*(3).

Koff, E., & Lyons, N. (2020). Implementing value-based health care at scale: the NSW experience. *Med J Aust*, *212*(3), 104-106.e101.

Laberge, M., Brundisini, F. K., Champagne, M., & Daniel, I. (2022). Hospital funding reforms in Canada: a narrative review of Ontario and Quebec strategies. *Health Research Policy and Systems*, *20*(1), 76.

Looi, J. C. L., Bastiampillai, T., Kisely, S. R., & Allison, S. (2021). Whose values are represented in value-based healthcare? *Australian & New Zealand Journal of Psychiatry*, *56*(6), 589-590.

O'Reilly, J., Busse, R., Häkkinen, U., Or, Z., Street, A., & Wiley, M. (2012). Paying for hospital care: the experience with implementing activity-based funding in five European countries. *Health Econ Policy Law*, *7*(1), 73-101.

Porter, M. E. (2010). What Is Value in Health Care? *New England Journal of Medicine*, *363*(26), 2477-2481.

Porter, M. E., & Teisberg, E. O. (2006). *Redefining health care: creating value-based competition on results*. Harvard business press.

Productivity Commission. (2017). *Shifting the Dial: 5 Year Productivity Review*. Productivity Commission.

Productivity Commission. (2022). *5-year Productivity Inquiry: The Key to Prosperity* [Interim Report]. Productivity Commission.

Schneider, E. C., Shah, A., Doty, M. M., Tikkanen, R., Fields, K., & Williams II, R. D. (2021). *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*. The Commonwealth Fund.