NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405
IN REPLY PLEASE QUOTE:

BH:AG

29 July 2016

Human Services Inquiry
Productivity Commission
Locked Bag 2
Collins Street East
Melbourne Vic 8003

Submitted via email: humanservices@pc.gov.au

To whom it may concern

The NSW Nurses and Midwives' Association appreciates the opportunity to provide comments in relation to increased competition, contestability and consumer choice in the human services sector.

The Australian Nursing and Midwifery Federation has also provided a submission focussed on particular areas of nursing and midwifery work that already operate in a competitive environment, which we endorse. However, in preparing our response we have elected to adopt a broader perspective, articulating why we do not support further expanding competition, contestability and consumer choice in the healthcare system.

Please contact me at this office if further information is required.

Yours sincerely

BRETT HOLMES
General Secretary

Address all correspondence to: General Secretary, 50 O'Dea Avenue Waterloo NSW 2017
P (02) 8595 1234 • 1300 367 962 F (02) 9662 1414 W www.nswnma.asn.au E gensec@nswnma.asn.au

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405
IN REPLY PLEASE QUOTE:

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses and registered nurses and midwives at all levels including management and education. The NSWNMA has approximately 60,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also dedicated to improving standards of patient care and the quality of health and aged care services.

NSWNMA is committed to the notion of health as a public good with shared benefits and shared responsibilities. We believe that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact. We are committed to publicly funded universal health insurance as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

While we recognise there are substantial reforms that can be made in order to improve the system, we believe that the principles on which Medicare was founded must be preserved: equity, efficiency, simplicity and universality. We absolutely reject the suggestion that asserting market based mechanisms will preserve or support these principles.

Address all correspondence to: General Secretary, 50 O'Dea Avenue Waterloo NSW 2017
P (02) 8595 1234 • 1300 367 962 F (02) 9662 1414 W www.nswnma.asn.au E gensec@nswnma.asn.au

While goals such as innovation, cost effectiveness, choice and consumer responsiveness are worthy and relevant, in the healthcare sector the primary performance measures are quality, safety, equity of access and affordability.

The Association rejects the orthodoxy that privately delivered services will always be more efficient than publicly provided services. This is particularly so in the healthcare sector where it is well understood that market mechanisms do not drive quality and efficiency.

Competition must not be an end in itself but a means to achieve improved performance. Experience in Australia, the US and the UK suggest that competitive markets in healthcare are often imperfect—the effects of information asymmetry, natural monopoly, vertical service integration, service co-dependencies, costs of market entry, and so on can make it difficult to realise the benefits of competition and can instead produce a range of adverse and unintended consequences such as excessive complexity, patient selection by providers, overtreatment, and lower clinical quality.[1]

A patient rarely has the knowledge and expertise to make an informed judgment nor is shopping around for better quality or price a realistic option. The leading types of ill health in Australia are cancer (16%), musculoskeletal disorders (15%), cardiovascular diseases (14%) and mental and behavioural disorders (13%).[2] The idea that a typical patient receiving care for any of these is in a position to bargain effectively with multiple providers, appraise quality and reduce demand in response to price rises is nonsense.

Further, fragmentation of care is a precursor to poor outcomes and inefficiency. With the growing burden of chronic and complex conditions, system reform must seek to address fragmentation whereas the proposed establishment of a market of multiple and competing providers will serve only to exacerbate this problem. A recent survey of doctors in the NHS indicated that (67%) of respondents were fairly or very uncomfortable with private providers delivering NHS services. The most common concerns cited were that private provision destabilised and fragmented NHS services and did not offer value for money.[3]

---

[1] Kieran Walshe, BMJ 2011;342:d2038, http://www.bmj.com/content/342/bmj.d2038
[2] AIHW, Australia's Health 2014, http://www.aihw.gov.au/australias-health/2014/ill-health/
[3] Adrian O'Dowd, BMJ 2016;353:i2232, http://www.bmj.com/content/353/bmj.i2232.short?trendmd-shared=0

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405
IN REPLY PLEASE QUOTE:

There is no compelling evidence that introducing contestable markets and competition in the Australian healthcare system will deliver improvements in terms of quality and safety. The objectives for healthcare delivery in the public sector are clear: quality, safety, efficiency and universal access. For private providers seeking to deliver the same services, the objectives are different: undercut the public service's price and deliver a profit.[4] So where will this profit margin come from?

We know from experience in Australia and abroad that nursing and midwifery services are the single biggest cost in running a hospital and they will most certainly be a key area targeted for cutting costs. This could be achieved through reduced staffing, diminution of skill mix, lower pay and conditions or a combination of these. Not only does this affect nurses and midwives but the evidence shows a very clear correlation between staffing ratios and quality and safety of care.[5,6,7,8,9]

---

[4] Ross Gittins, Think twice before throwing open the government coffers, SMH, 16 July 2016, http://www.smh.com.au/business/the-economy/think-twice-before-throwing-open-the-government-coffers-20160715-gq6dkw.html

[5] Twigg, D. E., Geelhoed, E. A., Bremner, A. P. and Duffield, C. M. (2013). The economic benefits of increased levels of nursing care in the hospital setting. *Journal of Advanced Nursing*, 69(10): 2253-2261

[6] Kalisch, B. J., Tschannen, D. and Lee, K. H. (2011). Do staffing levels predict missed nursing care? *International Journal for Quality in Health Care* 23(3), 302-308

[7] Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., & Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*, 24(4), 244-255

[8] Twigg, D., Duffield, C., Bremner, A., Rapley, P., and Finn, J. (2011). The impact of the nursing hours per patient day (NHPPD) staffing method on patient outcomes: a retrospective analysis of patient and staffing data. *International Journal of Nursing Studies*, 48(5), 540-548

[9] Cho, E., Sloane, D. M., Kim, E. Y., Kim, S., Choi, M., Yoo, I. Y. Yoo and Aiken, L. H. (2015). Effects of nurse staffing, work environments, and education on patient mortality: an observational study. *International journal of nursing studies*, 52(2), 535-542

Other strategies to boost profits include purchasing of less expensive equipment and targeting of more profitable services at the expense of less profitable services. This could be achieved through offering free screening services and developing mutually rewarding relationships with specialists and other providers. Over-servicing is a well documented outcome of profit seeking in the health care industry both here and overseas. We are also concerned about how private providers of public services will resist the temptation to use their influence to enhance the attractiveness of private care over the public waiting list.

To be clear, seeking profits is exactly the raison d'etre of private providers and an obligation for a publicly listed company on behalf of their investors. Containing labour costs, equipment costs, developing the more profitable aspects of a business, maximising sources of income whilst minimising outlays are all the things successful corporations do. It is exactly these imperatives that have led the US to a health system which delivers much less but costs far more. Unlike many other markets, profit seeking does not deliver efficiency in health.

There is a wide range of reforms that could be made to the Australian healthcare system to improve efficiency. These are well known and well documented: better management of chronic, non-communicable diseases; prudent investment in primary care; investment in primary prevention and public health; improved approaches to end-of-life care; reducing avoidable hospital admissions; avoiding ineffective treatments[10]; targeting cost variations within and across the public hospital sector[11]; payment innovations[12]; improvements to the operation of the PBS. Such measures are widely supported by most stakeholders and would provide real and meaningful benefits by driving efficiency whilst retaining the equity, quality and cost-containment effect of a robust universal public health system.

---

[10] Duckett, S. & Breadon, P. 2015 Questionable care: avoiding ineffective treatment, Grattan Institute, http://grattan.edu.au/report/questionable-care-avoiding-ineffective-treatment/
[11] Duckett, S. & Breadon, P. 2014 Controlling costly care: a billion dollar hospital opportunity, Grattan Institute, http://grattan.edu.au/report/controlling-costly-care-a-billion-dollar-hospital-opportunity/
[12] OECD 2016 *Better Ways to Pay for Health Care,* OECD Health Policy Studies, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264258211-en

We consider the shift toward privatising elements of health care currently delivered in the public system a stealth strategy of incremental cuts to reform Medicare as a safety-net for the poor.

In a mixed public-private system, a strong, publicly funded health system plays an important role in containing the overall rate of inflation of health costs. Weakening the public system while strengthening the private sector creates incentives that result in:

- Increased waiting times in the public sector as doctors have an economic incentive to serve private patients.
- Incentives to maintain long public waiting lists in order to increase the attractiveness of more lucrative private care. How will the private operators of the new Northern Beaches Hospital, which will provide both public and private beds, deal with the temptation to create circumstances that optimise the attractiveness of their more lucrative private beds?
- Ethical questions when entrepreneurial providers refer patients to private care in which they have financial interests.
- Growth in input prices due to competition between the public and private sector. In the public sector this leads to either a reduction in the provision of services or the need for public spending growth to maintain previous levels of service.
- Privatisation leads to poorer working conditions for the nursing and midwifery workforce we represent.

We fundamentally reject the suggestion that the introduction of competition and contestable markets represents a superior approach to curb the growth in health costs. Further, we believe the demonstrable risk of excessive complexity, fragmentation, lack of transparency and accountability, price inflation and diminishing quality and accessibility makes our public health system an inappropriate target for competition policy.

The overwhelming evidence is that our ageing population will not have the catastrophic impact on the sustainability of Medicare that many vested interests like to portray. Analysis of the evidence indicates that a substantial proportion of the growth in costs in health can be attributed to developments in technology and changes to practice.[13]

That is not to say the health system should disregard the implications of our ageing population. There will be a rise in the burden of chronic diseases. It will be increasingly important that people with chronic diseases avoid expensive hospitalisations through easy access to early intervention, prevention and education about self-management in the most cost-effective settings. The correct response to this challenge is to invest in primary care and to remove barriers to access. Winding back of the universality of Medicare, expanding competitive pressures or increasing private funding is precisely the opposite of what is required.

The expansion of competition in Australia's health system will necessarily expand the role of health insurance. The scale and unpredictability of health costs means that insurance, be it public or private, is inevitably a major feature of the industry. Individuals who are insured have an incentive to maximise the return they receive from their purchase of insurance. Doctors also have an incentive to over-service and overcharge when they know that their patients are covered by insurance. Moral hazard is associated with any insurance market but has particular implications for the healthcare market. However when that insurance is universal there are far greater opportunities to manage such issues.

[13] Duckett, S., Don't just blame older Australians for increased hospital demand. *The Conversation* *https://theconversation.com/dont-just-blame-older-australians-for-increased-hospital-demand-62622*

Local and global evidence shows the more private health insurance is used to fund health care, the more expensive a health system becomes, without any improvement in the quality of care. The administrative costs of the public subsidy-reliant private health insurers including profit margin are about three times that of Medicare. Private insurance does not contribute to efficient distribution of resources because of competition amongst insurers – they are unable to influence the prices demanded by providers. In contrast, a single national insurer like Medicare has the market power to standardise prices and utilisation.

The Australian healthcare sector is no stranger to the negative outcomes associated with the introduction of models that allow private interests to tender for the provision of public services, and the outcomes have been distinctly underwhelming.

PPPs for new hospitals are usually embraced by governments as a means of delivering infrastructure without adding to public debt. The justification purported is they provide value-for-money and deliver improved services.

Australia's first major partnership involving delivery of clinical services was the Port Macquarie Base Hospital in NSW which commenced operations in November 1994. Most people in NSW are aware of the sorry tale of Port Macquarie Base Hospital – famously described by the Auditor General as a contract where the government was "paid for it twice and then gave it away". Costs were 20% higher than those in the public sector and the majority of the risks were passed on to the government.

It is worthwhile to examine the performance of the PMBH on the criteria of quality of services and value for money. On the first point (quality of services), a number of performance indicators for the PMBH were set between the NSW Department of Health (DoH) and Mayne Nickless[14] which included elective surgery waiting times. Peer hospitals for comparison were also set between DoH and Mayne. In 1998, waiting times for elective surgery at the PMBH were double the state average and it was the state's worst performing hospital. Within NSW, the PMBH had the State's largest number of patients with waiting times longer than a year.

By 2003, at the end of its operating period, there were 333 elective patients with waiting times for surgery of longer than a year. In comparison, Coffs Harbour and Manning Base public hospitals, in the same peer group, had just 7 and 5 patients respectively with waiting times longer than a year.

La Trobe Hospital in Victoria and Robina Hospital in Queensland also resulted in contract failure. The Victorian Minister for Health entered into a 20-year contract with Australian Hospital Care in 1997 for the design, construction and operation of the La Trobe Regional Hospital. It commenced operations in October 1998. After 6 months of operation, Australian Health Care approached the Liberal Government of Victoria for more funding following significant operating losses. The government did not assist. In November 2001, the staff of Latrobe Regional Hospital transferred back into state employment and in 2002, the ownership of the hospital reverted back to state management.

The script for Robina Hospital was almost identical to La Trobe Regional Hospital: the hospital operator, Sisters of Charity, approached the government in the first six months of operation to alleviate operating losses and to seek more favourable contract provisions.

[14] Chung, D. (2009). Developing an analytical framework for analysing and assessing public-private partnerships: a hospital case study. The Economic and Labour Relations Review, 19(2), 69-90.

In both Robina Hospital and La Trobe Regional Hospital, the bid was based on the assumption that greater operating efficiencies than those in the public sector would be achieved; indeed, this is essential for value-for-money and for the partnership to be preferable to the comparable public sector. The government did not assist and the operator continued to make operating losses. After just two years, Robina Hospital reverted to state management.

There are a number of other Australian examples of how this model has failed the twin objectives of value for money and performance. Most recently we have receive the most recent review of cancer outpatient treatment from the NSW Bureau of Health Information. Why do cancer patients receiving outpatient treatment rate the privately run Chris O'Brien Lifehouse, the most celebrated and best funded cancer hospital in NSW[15], as underperforming compared with public counterparts against a range of important clinical quality measures?[16] Lifehouse is a private facility that is contracted by Local Health Districts to provide care for public patients. While the physical environment and comfort rated well, many important clinical and quality measures underperformed[16]. The exact reasons for this underperformance are not clear, but it is clear from the data that substantial investment has been made to enhance the appeal of the built environment. Whether or not similar emphasis has been placed on quality of care is not so clear, and the data indicates significant failings.

In our view Lifehouse provides a window into what overemphasis on competition, contestability and user choice does in healthcare: patients cannot be expected to exercise an informed assessment of the quality of the service or clinical outcomes, but may be impressed by modern design and a sleek built environment. All the other services on which data was collected are public, operating without the pressure to attract patients or deliver an operating surplus, and they are delivering superior care at a more efficient price.

---

[15] Alexander, H. 20 July 2016 Chris O'Brien Lifehouse gets poor patient ratings for symptoms, participation and positivity, Sydney Morning Herald, *http://www.smh.com.au/national/health/chris-obrien-lifehouse-gets-poor-patient-ratings-for-symptoms-participation-and-positivity-20160719-gq94u1.html*

[16] Bureau of Health Information. *Patient Perspectives – How do outpatient cancer clinics perform?*
Experiences and outcomes of care, February and March 2015. Sydney (NSW); BHI; 2016.http://www.bhi.nsw.gov.au/__data/assets/pdf_file/0004/320836/patient-survey-outpatient-cancer-clinics-2016.pdf

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405
IN REPLY PLEASE QUOTE:

Fortunately Australia still has a viable public system. But for how much longer? A PPP is not a true public hospital; it is an arrangement that gives a profit seeking entity control over public services. This is the wrong path for Australia's health care system.

The current raft of Free Trade Agreements seek to introduce a standstill and ratchet approach to regulation. This, combined with the Investor State Dispute Mechanisms within the trade agreements, aims to reduce the reach of government regulation on trade and services. The Trade in Services Agreement, though not yet finalised, clearly seeks to increase the privatisation of public services where those services are currently provided by both sectors. The Australian government, should it privatise healthcare services further, will increase the risk of losing its regulatory ability and could be pressured into privatising new or existing services regardless of the community's wishes.

While competition drives quality and efficiency in many sectors, we believe that the evidence of market failure in healthcare is so significant that it would be a mistake to rely on competitive pressures as a primary mechanism to drive quality and efficiency in healthcare.

Serious commitments must be made to ensure that the rate of inflation of costs in health is contained in the future. We have listed some and there are others. None of them are contingent on carving out sections of our high performing public system to private interests. The Australian community has repeatedly expressed a clear preference in favour of maintaining public health services and in opposition to privatisation.

It is vital that the Australian Government maintains the lever of universal comprehensive insurance to maintain a downward pressure on overall health spending. The shift towards greater user pays, greater privatisation and co-payments is profoundly inconsistent with the goals of efficacy and equity and must be rejected.

Address all correspondence to: General Secretary, 50 O'Dea Avenue Waterloo NSW 2017
P (02) 8595 1234 • 1300 367 962 F (02) 9662 1414 W www.nswnma.asn.au E gensec@nswnma.asn.au