# Submission to

## the Productivity Commission

## Productivity Review

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## Introduction

The Queensland Nurses' Union (QNU) thanks the Productivity Commission (the Commission) for the opportunity to make a submission to the Productivity Review (the Review).

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives, 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 54,000 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 in Queensland are members of the QNU.

We note the Australian government has asked the Commission to analyse productivity in the non-market sector which comprises healthcare and social assistance, public administration and safety and education and training. The Discussion Paper (Productivity Commission, 2016, p. 3) states 'there should not be an assumption that future microeconomic reforms in these areas use the same approaches of competition, corporatisation, privatisation and pricing that were the keystone of the pre-1990s reform agenda'.

While we acknowledge the review may not pursue such a reform agenda, we state at the outset our opposition to the privatisation of Commonwealth, State or Territory assets. 'Privatisation' can take several forms, including:

- Sale of assets to the private sector;
- Contracting out or out-sourcing services to private sector;
- 'Offshoring' services.

We challenge the argument the State needs to sell well-performing assets or outsource the provision of services to enable further investment on infrastructure or for any other purpose.

We have made this position very clear on many occasions including submissions to various inquiries and a statewide media campaign during 2013 objecting to the privatisation agenda of the previous Newman state government in Queensland.

In our view, the sale of state-owned assets

- transfers their ownership and benefits from the whole community into the hands of a few private interests with the capacity to invest;
- has particular impact on services in rural and remote areas;
- increases consumer costs;
- leads to job losses;
- abrogates the government's community service obligations.

There are other innovative ways in which government can increase productivity and raise funds for infrastructure and essential services which we have outlined in this submission.

Our submission concentrates on nursing and midwifery and we make recommendations we believe will enhance productivity to the healthcare sector in the long term.

## Recommendations

The QNU recommends:

- the federal parliament enacts legislation preventing privatisation without full public disclosure of:
  - the reasons for this action;
  - the projected cost savings;
  - measures to protect public sector jobs; and
  - the ways in which unions, workers and the community have been involved in the decision.
- The Commission investigates the provision of national legislated nurse/midwife-to-patient ratios incorporating a public reporting framework as a long term investment in healthcare;
- The Commission explores the concept of bundled payments for midwifery led models of care;
- The QNU recommends the Commission explores a much wider use of Nurse Practitioners in providing primary, acute and aged care. The benefits of other advanced practice/innovative nursing roles such as Nurse Navigators should be

further explored.

- The Commission investigates the implementation of a financial transactions tax at rates of around 0.05% (5 cents for every $100 being traded) as a fairer means of raising revenue to support the upkeep and expansion of government owned assets.

## Role of Government

We believe governments have a major role in health service delivery, particularly in a state the size of Queensland where inevitably private suppliers will only choose to provide services in the most profitable locations at the expense of the rest. Capacity to pay should not determine access to essential services.

Queensland is a vast state with a decentralised population in regional and remote centres. These communities experience acute disadvantage, largely as a result of their remoteness. Governments have an obligation to provide services to the community based, as far as is practicable, on fairness and equity.

Those who envisage a small role for government while markets determine the effective provision of most goods and services contrasts with the views of others who believe government has an obligation to provide fair, equitable, affordable services to the community that elected it.

## Privatisation in Health Care

There are numerous examples of privatisation in health which demonstrate how the transfer of capital from the public to the private sector has led to decline in the functioning and provision of services. This has ultimately required State intervention and capital expenditure to re-establish effective operation.

In our view, creating a crisis in health spending provides the impetus to promote and implement an agenda to privatise the health sector through a refrain of 'deregulation' and 'choice'.

Section 7.3 of the national audit commission's report (2014) makes this quite clear.

> Putting health care on a sustainable footing will require reforms to make the system more efficient and competitive. The supply of health services must increase in line with growth in demand and improvements in productivity are a natural way of ensuring this. More deregulated and competitive markets, with

appropriate safeguards, have the greatest potential to improve the sector's competitiveness and productivity.

These tenets have also resonated in the recent *Competition Policy Review Report* (Competition Policy Review Panel, 2015) that aims to change competition policy settings to reflect a 'privatised' health system.

Recommendation 2 – Human Services – of the *Competition Policy Review Final Report* reads:

Each Australian government should adopt choice and competition principles in the domain of human services. Guiding principles should include:

- User choice should be placed at the heart of service delivery;
- Governments should retain a stewardship function, separating the interests of policy (including funding), regulation and service delivery;
- Governments commissioning human services should do so carefully, with a clear focus on outcomes;
- A diversity of providers should be encouraged, while taking care not to crowd out community and volunteer services;
- Innovation in service provision should be stimulated, while ensuring minimum standards of quality and access in human services.

When developing implementation plans, governments can expand on these principles to achieve their goals (Competition Policy Review Panel, 2015).

We recognise the recommendations were made within the context of competition policy, however we strongly oppose the elevation of market based principles in health service delivery at the expense of government in providing free at point of service, high quality, accessible health care. The guiding principles appear to be premised on a fundamental acceptance that competition will automatically deliver better outcomes for Australians regardless of the sector. We reject this notion, in particular the claim that 'user choice should be placed at the heart of service delivery'. ***Quality and safety*** are at the core of health service delivery, not user choice, and it is the role of government to fund and provide it.

We are not saying there is no role for competition. Rather competition principles must not replace a fundamental responsibility of government towards its citizens. The national audit commission's recommendations and those put forward in the *Competition Policy Review Report* are at odds with our view of health care delivery, particularly as these two bodies are seeking to reorient fundamental understandings about competition and the role of government.

Combined with its general view on the role of government, safety nets and increased private payments, the audit commission's proposals would eventually dismantle Australia's public hospital system and, as evident in places like the USA that run privately-dominated hospital systems, lead to massive financial risk for most low and middle income Australians. Competition policy in healthcare cannot favour private interests above the public interest, under the guise of 'choice'.

The audit commission's other key health/Medicare recommendations make it clear that it wants to force increasing numbers of people into private health insurance and out of a national, government-run social insurance arrangement and eventually leave free-at-the-point-of-service hospital care as a charitable system for the "most" disadvantaged. This is in keeping with its general undervaluing of government programs.

To commence this process, the audit commission recommends a number of initial changes to reduce spending on healthcare and hospitals and force high income earners into private health insurance.

Section 7.3 of the audit commission's phase one report (2014) calls for a broader, long-term review (encapsulated in Recommendation 18) with a heavy emphasis on privatisation ideas such as a universal health insurance arrangement. Such a scheme would make health insurance mandatory for all Australians. The Commonwealth would pay premiums for low income and high risk groups and also pay for the health insurance of all children. It would be compulsory for people on higher incomes to take out private health insurance.

Under this scheme, Medicare would remain as the default insurer for those on lower incomes, with their premiums paid by government direct to Medicare. People on low incomes could alternatively choose a private health insurer, with their premiums still paid by the government.

The QNU strongly opposes this type of policy change. In Australia, where the public hospital system is mostly government-owned and run, we spend less than 10 per cent of our Gross Domestic Product (GDP) on healthcare services. In the USA, where the system is mostly privately owned and operated, they spend over 17 per cent of their GDP and still cannot provide equitable access to tens of millions of their citizens.

**Recommendation**

The QNU recommends the federal parliament enacts legislation preventing privatisation without full public disclosure of:

- the reasons for this action;

- the projected cost savings;
- measures to protect public sector jobs; and
- the ways in which unions, workers and the community have been involved in the decision.

## Minimum Nurse/Midwife-to-Patient Ratios

Establishing and maintaining safe workloads has been a long-term priority for nurses and midwives in Queensland. Until the recent amendments to the *Hospital and Health Boards Act 2011*, there were no laws governing how many patients could be safely allocated to a single nurse/midwife. The absence of such laws resulted in nurses and midwives frequently experiencing unsafe workloads and expressing concerns for patient safety.

There is now a substantial body of research (Aiken et al., 2014; McHugh et al., 2013; Twigg et al., 2013) that demonstrates nurse-to-patient ratios and endorsed skill mix levels (the proportion of Registered Nurses providing care) are economically sound methods to save lives and improve patient outcomes.

National and international studies have irrefutably shown that the number, skill mix and practice environment of nurses directly affect the safety and quality performance of health services.

Health services with a higher percentage of Registered Nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and less adverse events such as failures to rescue, pressure injuries and infections.

The following statistics give a snapshot of the important correlation between nursing workloads and patient outcomes:

- Every one patient added to a nurse’s workload increased the likelihood of an inpatient dying by 7% (Aiken et al., 2014);
- Every 10% increase in bachelor-educated nurses decreased the likelihood of an inpatient dying by 7% (Aiken et al., 2014);
- Every one patient added to a nurse’s workload increased a medically admitted child’s odds of readmission within 15-30 days by 11% and a surgically admitted child’s likelihood of readmission by 48% (Tubbs-Cooley et al., 2013).

Nurse/midwife-to-patient ratios will contribute to organisational productivity, hospital efficiency and continuity of patient care by increasing staff satisfaction, decreasing attrition

rates, reducing patient readmission and adverse events, limiting service variation and improving equality across the healthcare sectors.

We recognise the additional nursing and midwifery staff may involve extra cost at the outset. In the longer term however, we anticipate improved patient outcomes and reduction in costs associated with adverse events, readmissions, complications and mortality. The Queensland government has committed to demonstrating this through the establishment of an agreed evaluation framework. Importantly, public reporting of compliance with ratios and patient outcomes is a cornerstone of our campaign for minimum rations. We therefore support the Commission's focus on the need for high quality publicly available data to support informed decision making (incorporating a public reporting framework.)

Queensland and Victoria are the only states to have legislated nurse/midwife-to-patient ratios.

**Recommendation**

| The QNU recommends the Commission investigates the roll out of ratios nationally as a long term investment in healthcare. |
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## Midwifery led continuity of care models

A significant body of research demonstrates midwifery continuity of care models provide optimal outcomes for women and their babies (Sandall et al., 2016). Midwife-led continuity models provide care from the same midwife or team of midwives throughout the pregnancy, birth and the early parenting period.

The focus on cost and outcomes in maternity care in the recent Lancet series on Maternal Health demonstrates that Australia's increasing levels of medicalisation in birth are not improving outcomes and are negatively impacting the health budget (Miller et al., 2016; Shaw et al., 2016). Midwifery-led models of care, and potentially other evidence based innovations in maternity care, could be well supported by the introduction of bundled payments.

Under a bundled payment model, providers and/or healthcare facilities are paid a single payment for all the services performed to treat a patient undergoing a specific episode of care. An "episode of care" is the care delivery process for a specific condition or care delivered within a defined period of time.

For example, when a patient has surgery, payers would traditionally reimburse the hospital, surgeon, and anesthesiologist separately for their part in the treatment. Through a bundled payment model, the payer would collectively reimburse the providers involved, using a set price for the episode of care, normally based on historical costs.

Providers who exceed the pre-arranged reimbursement for the episode bear the financial responsibility for additional costs. The aim is to encourage standardised, cost-effective care decisions.

Bundled payments allow hospitals and other providers to work more closely together across many settings and offers a method for reducing the increasing costs of healthcare.

In our view, most women should be offered midwifery continuity models of care and therefore we are supportive of models of funding which will assist to drive reform in this area. A focus on consumer outcomes and minimum datasets as per national and international standards is highly recommended when bundled payments are adopted to support the continual improvement and delivery of safe, high quality healthcare.

All stages of maternity should be included in the bundled price. Antenatal and postnatal care are easily defined and could be bundled separately i.e. a bundle for antenatal care and a bundle for postnatal care. This will allow for greatest flexibility in costing and funding.

A bundled approach to funding maternity care across all sectors (Medicare, hospital funding, and private health funders) would assist in providing the most efficient models of funding and make midwifery led models of care more accessible to Australian women.

**Recommendation**

The QNU recommends the Commission explores the concept of bundled payments for midwifery led models of care.

## Nurse Practitioners

Nurse practitioners (NP) have the capability to provide high levels of clinically focused nursing care in a variety of contexts in Australia. They care for people and communities with problems of varying complexity.

In the contemporary health setting the Nurse Practitioner (NP) is a highly skilled nursing role, generating immediate sustainable capacity in health care modelling and delivery. NPs have the capability to provide high levels of clinically focused nursing care in a range of contexts for people and communities with problems of varying complexity. The number of NPs has continued to grow[1] as has the research on advanced practice nursing.[2]

NPs are educated within a nursing model and must first be an experienced registered nurse (RN) and complete a Masters degree. NPs are likely to be educated in a speciality within a particular setting. Their scope of practice is built on the platform of the RN scope of practice, and must meet the regulatory and professional requirements for Australia including the *National competency standards for the registered nurse*, *Code of ethics* and *Code of professional conduct* (Nursing and Midwifery Board Australia, 2013).

NPs are capable of managing episodes of care, including wellness focused care. NPs may be the primary provider of care or part of a care team. They collaborate and consult with health consumers, their families and community, other professionals, including health personnel, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care (Nursing and Midwifery Board Australia, 2013).

NPs are not the only nursing role that can and do improve the provision of integrated holistic care. Other advanced practice and specialised nursing roles (such as newly created Nurse Navigator positions in Queensland ) also deliver improved health outcomes and provide better co-ordinated care and therefore potential cost savings. These roles demand further consideration.

**Recommendation**

The QNU recommends the Commission explores a much wider use of Nurse Practitioners in providing primary, acute and aged care. The benefits of other advanced practice/innovative nursing roles such as Nurse Navigators should be further explored.

## Alternative models of funding public health service delivery

If Australia is to keep growing national income as the terms of trade decline it needs a significant increase in both infrastructure and operational capital investment. The QNU

[1] The latest Nursing and Midwifery Board Australia (NMBA, 2015) statistics indicate there are 342 NPs in Queensland.

[2] See for example Duffield C. & Gardner, G. (2014) *Answer 4 Nursing and Midwifery* Report of the Australian Nursing/Midwifery Workforce Survey.

believes there are alternatives other than privatisation as a means of increasing productivity and funding new infrastructure including a fairer taxation system where large business interests contribute more reasonably to Australia's economy. We suggest effective corporate tax avoidance measures and the introduction of a financial transactions tax could fund new infrastructure rather than selling off government-owned assets.

The financial transactions tax is a modest levy of up to 0.05% on the trading of specific financial instruments such as stocks, bonds, derivatives, futures, options and credit default swaps. It is sometimes referred to as the 'Robin Hood Tax'. Each time one of these financial products is traded, the levy applies. The tax targets the large profits made on risky, high-volume trading rather than the everyday transactions made by the general population.

**Recommendation**

The QNU recommends the Commission seriously considers the adoption of this tax as a fairer means of financing infrastructure and investment in capital.

## Conclusion

The QNU is always willing to discuss genuine reform ideas. We are continually involved in negotiations for enterprise agreements and workplace initiatives aimed at improving the efficiency, productivity and efficacy of the health and aged care systems. However, we will oppose at every opportunity any attempts to privatise health care and sell government owned assets under the guise of productivity. We see these moves as an attack on the Australian way of life, one which new and established governments enter into at their peril.

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