

29 July 2005

Commissioners Mike Woods and Helen Owens  
Health Workforce Study  
Productivity Commission  
PO Box 80  
BELCONNEN ACT 2616

*Email: [healthworkforce@pc.gov.au](mailto:healthworkforce@pc.gov.au)*

Dear Commissioners Woods and Owens,

**Re: Response to Health Workforce Issues Paper**

Thank you once again to provide feedback into this important study. In April this year the Queensland Nurses' Union (QNU) wrote to the Commission providing background information that we believed would be of interest to this inquiry. We hope that this information has been of assistance and would be happy to meet with representatives of the Commission at any time to elaborate on issues raised in the materials supplied by the QNU.

As you would no doubt be aware, there are currently two inquiries underway in Queensland that are of direct relevance to this inquiry. These are the Commission of Inquiry into Bundaberg Hospital and the Queensland Health Systems Review. Although the terms of reference for these two inquiries differ from the issues under consideration by the Commission in your review, health workforce issues are none the less of central importance. One limitation of the two Queensland inquiries is that they are tending to focus on the public sector. However it should be noted that the broader issues raised (for example in the QNU submission to the Queensland Health Systems Review) are equally applicable to other parts of the health sector. It is our strong view that with regards to health workforce and other critical issues such as quality, safety and complaints handling there must be a whole of health sector examination (across public and private sectors including aged care) and that there is an urgent need to establish mechanisms to ensure consistency of approach and standards across public and private sectors.

The QNU has been (and continues to be) preoccupied with making submissions to the two important Queensland inquiries currently underway. For this reason we will not be able to provide a detailed submission on your issues paper. We request that you give consideration to the QNU submission to the Systems Review of Queensland Health (copy enclosed – minus attachments) as many issues relating to health workforce are covered in this document. Rather than repeat the issues and arguments contained there in this submission we will instead briefly address some specific issues raised in your issues paper and also expand upon some of the issues that we highlighted in our initial submission to your inquiry. We will not specifically address the questions posed by the Commission in their first circular as in most instances these issues are addressed in this submission or the attachments that are provided.

We also enclose for your information a detailed report of independent research conducted late in 2004 by the University of Southern Queensland (USQ) for the QNU. The final report, *Nurses. Worth listening to.* provides invaluable insight into issues affecting the nursing workforce in the public sector, private hospital and aged care sectors in Queensland. This is a repeat of research conducted in 2001 by the USQ and QNU and as such provides a rare insight into issues affecting nursing recruitment and retention over time. To our knowledge this is the only research of its type into the nursing workforce that has been conducted in Australia, if not the world. We previously provided the Commission with the summary of the 2001 research. In our view the findings of the 2001 and 2004 research should be included in the Commission's consideration of issues of job satisfaction. Some other study's on job satisfaction have already been acknowledged by the Commission and were highlighted in the issues paper in Box 4 on page 21. The QNU would be happy to facilitate a meeting between USQ researchers, QNU officials and Commission staff to discuss this important research if you would like to discuss the findings further.

The QNU's federal body is the Australian Nursing Federation (Federal Office) and we support the submissions made to this inquiry by that organisation and other branches of the ANF.

### **Comments on Productivity Commission Health Workforce Issues Paper**

The QNU is in agreement with the broad thrust of the issues paper and agree that the issues that have been highlighted require further attention. We do however wish to provide brief comment on a number of issues raised in the issues paper.

#### **Pages 20 – 22 Productivity, quality and job satisfaction problems:**

The QNU strongly believes that there has been an over-emphasis on productivity gains and efficiency in health in recent years and that this has occurred at the expense of equally important factors such as effectiveness (including quality) and equity. Queensland's public health system is lauded by our Premier as being the most efficient in the country, but just how effective is it?

One critical issue that requires urgent close attention is the changes that have occurred in relation to health workforce skill mix in recent years. These have occurred in the name of enhanced productivity but in the absence of any analysis of the impact that these changes have on effectiveness of care, especially quality. For example, in recent years the growth of so called third level (unregulated) nursing workers has been much higher in Queensland than any other state ( 47.5 % growth in employment of Personal Carers and Assistants in Nursing occurred in Queensland between 1987 and 2001 compared to a 1.7% decline nationally during the same period – see table below.)

**Table 7. Employment growth of Personal Carers and Nursing Assistants by State and Territory, 1987-01<sup>1</sup>**

New South Wales	13.4	20.0	0.9
Victoria	7.4	-8.0	-2.3
Queensland	9.9	47.5	3.9
South Australia	2.4	-60.9	-5.4
Western Australia	4.6	-18.7	-1.7
Tasmania	0.9	-41.6	2.5
Northern Territory	0.3	0.8	-2.2
Australian Capital Territory	0.4	2.9	-0.1
Australia	39.3	-1.7	-0.2

**Note:** The annual rates were estimated by fitting a log linear model to the annual employment data. Only estimates for Victoria, Queensland South Australia and Western Australia are significant at less than 10 per cent level.

Our concern about this trend and others regarding skill mix and workloads should not be interpreted as the QNU not being willing to participate in a proper examination of health worker roles and skill mix. We are keen to undertake such an examination, but it must be based on evidence and occur within an appropriate framework of regulation. The call for appropriate regulation should also not be read as “code” the QNU wishing to maintain “unduly rigid delineation” of roles. The QNU has a large number of Assistants in Nursing (currently unregulated health workers, though not necessarily un qualified) and these workers are a valued member of the nursing team. We instead have argued for many years now that these workers (and any other currently unregulated worker undertaking nursing work) should be appropriately regulated by the Queensland Nursing

<sup>1</sup> Shah C and Burke G (2002), *Job Growth and Replacement Needs in Nursing Occupations*, DEST (National Review of Nursing Education) Canberra, page 40.

Council. If they are performing nursing work they should be accountable for the standard of the work performed (and hence clinical outcomes), work within a nursing model of care and report to a registered nurse. Failing to regulate such workers is a significant flaw in the current regulatory regime in our view. Our arguments for this change in regulation are outlined in our 2003 submission to the National Competition Policy Review of the Queensland *Nursing Act 1999*. A copy of this document is enclosed for your information.

The QNU is keen to examine issues of skill mix and numbers and appropriate regulation in an open, evidence based and transparent way. We are aware that there are a number of research projects currently underway that are examining issues of nursing workloads and skill mix (in New South Wales and Queensland) and eagerly await the outcomes of these projects. The QNU has been briefed fully on the Queensland project and is represented on its expert working panel.

On the issue of job satisfaction (Box 4, page 21) please see the enclosed research report from the recent USQ research for further detailed information on job satisfaction issues for Queensland nurses. In summary this research highlights that issues that need to be addressed include but are not limited to:

- unsustainable workloads impact upon the ability of nurses to deliver quality individualised care;
- unsupportive and unsafe work environments (especially the current high levels of workplace violence);
- remuneration and conditions of employment deficiencies and inequities;
- deteriorating morale of nurses that contributes to wastage of nurses from the system;
- ensuring access to appropriate ongoing education and development for nurses.

The issues of productivity, quality and job satisfaction are inter-related. Please see the enclosed QNU submission to the Systems Review of Queensland Health for further details of our concerns and recommendations about these matters.

### **Pages 23-32 – What underlies these problems?**

**Fragmentation of regulatory arrangements:** We agree that there is a need for greater consistency with regards to regulation of health care workers. It is assumed that the state-based responsibility for nursing registration (Box 5 page 25) is merely meant to be indicative or arrangements for health professionals, but it can be read as highlighting that the regulatory arrangements for nursing require particular attention. In our view the regulation of nurses is far more appropriate than the regulatory arrangements for other health professionals. There is much better coordination between nursing regulatory bodies and from our experience the processes of nursing regulatory bodies such as the Queensland Nursing Council (QNC) are far more rigorous than the other health professional regulatory bodies in Queensland. There is certainly a need for improvements to regulatory processes but it is essential that these occur in a manner that

does not compromise the professional autonomy of different health professional groups. Nursing, for example, is a separate and distinct professional group that has struggled for years to be free from the “medical model”. The QNU would strongly oppose any action that would see nursing lose its autonomy and professional status. The Commission must not interpret sensitivity about such matters as being merely about a professional turf war. These issues are related to entrenched power imbalances in health. The culture of health and issues of power imbalances and gender that must be acknowledged openly and dealt with in any serious examination of health workforce matters. Unfortunately discussion of these issues is largely absent from your issues paper but are critical barriers to appropriate health workforce planning. There is a need for improved integration, consistency of approach and gaps in regulatory frameworks that must be addressed. The QNU are keen to participate in meaningful discussions about improved job design.

**Shortcomings in workforce planning:** Lack of meaningful data and appropriate mechanisms to facilitate an integrated approach to health workforce planning are critical barriers that must be overcome. It is also essential that we overcome an entrenched culture of “short termism” and start to undertake and adequately resource planning for the medium to long term. Such medium to long term planning will be essential given the demographic challenges confronting Australia. Research reported in a recent edition of the Medical Journal of Australia (*Baby boomer doctors and nurses: demographic change and transitions to retirement*) highlighted that attrition of baby boomer clinicians in coming years will place unprecedented pressure on Australia’s health system. Changing working patterns (and priorities) of generation X and Y clinicians (especially the trend to decreased working hours for medical practitioners in this age cohort) will exacerbate shortages. The researchers concluded that there was an urgent need for:

*Policies and incentives to encourage ongoing employment among older clinicians, albeit at reduced hours, are crucial if the Australian health workforce is to be adequate to meet the growing community demand of the 21<sup>st</sup> century.<sup>2</sup>*

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<sup>2</sup> MJA 2005; 183: 80–83, Schofield, D and Beard J, “Baby boomer doctors and nurses: demographic change and transitions to retirement”, page 80.

There is a lack of appropriate forums to facilitate a coordinated approach to integrated health workforce planning. It is essential that this deficiency be addressed as a matter of urgency. We strongly believe that there is a need to involve all key stakeholders in a mechanism to progress genuine and far reaching health reform at both the state and federal levels. As the federal government has consistently indicated unwillingness to date to form such a body at the national level we are presently concentrating our efforts at the state level to see if it is possible for such a body established to be established there. In our view a sub group of a health reform body would be charged with responsibility of coordinating health workforce planning across sectors. The QNU made a number of recommendations regarding strategies to improve workforce planning in our submission to the Queensland Health Systems Review and we strongly urge you to refer to the enclosed submission for further details.

**Insufficient coordination between governments, planners, educators and service providers:** The QNU believes this is a critical deficiency and acknowledges that the issues raised as shortcomings on page 29 of the issues paper must be addressed. We also strongly believe that another shortcoming needs to be examined as part of the Commission's deliberations – inconsistency with regards to the meeting of costs of education. For example, with the exception of a small number of post-basic educational scholarships that are available for nurses, the cost of undertaking post graduate courses of study are met by the individual nurse through PELS. This contrasts to post basic medical specialist qualifications costs that are in large part met by government. There are also significant inconsistencies between health workers with respect to access to paid leave and other support for study and development. For example, at the recent QNU conference Queensland Premier Peter Beattie announced that 20 nursing scholarships per year would be provided in the future for nurses to undertake Masters levels nurse practitioner courses. (Funding of \$160,000 per year will be provided for these scholarships but the duration of this initiative has not been announced.) In the next paragraph he announced that 235 bonded scholarships for undergraduate medical students who are prepared to work in areas of workforce need. (This initiative with Griffith University will occur over the next 5 years, at a cost of \$41.6 million.) Both initiatives are welcome, but there are a number of obvious problems with the announcements. Given the size of the nursing workforce compared to the medical workforce it would be expected that a greater number of scholarships would be offered for nurses – not even one tenth of the number offered to undergraduate medical students have been offered for nurse practitioner scholarships. Shortages and mal distribution exist in both the nursing and medical workforces and given the significance of current nursing shortages surely from a policy perspective it must be acknowledged that underlying shortages must be comprehensively addressed before extension of roles is genuinely contemplated. (Or failing this at least strategies to address both issues need to occur concurrently.) Providing incentives to expand roles in the absence of strategies to address underlying shortages effectively prevent appropriate extension of nursing roles given that such expansion merely exacerbates the shortages in the general nursing workforce.

The issue of incentives and the current ad hoc nature of workforce planning require particular close examination by this inquiry. As it is difficult to obtain information on the

cost of post basic medical education through the specialist colleges we believe that it would be a most worthwhile exercise for the Commission to undertake a comparison of the costs involved in health worker education, who meets these costs and other factors such as length of courses of study. Just the process of gathering and consolidating this information and then making it publicly available in a form that enables easy comparison is an important first step in ensuring openness and transparency and encouraging debate.

It is recommended that:

The Productivity Commission arranges for the preparation of a report on the range undergraduate and postgraduate qualifications of health workers (including specialist medical college's qualifications) and that this includes an analysis of duration of course, costs involved and who meets these costs.

**Funding arrangements need to be urgently reviewed:** The various shortcomings of different forms of funding arrangements for health practitioner services (fee for service, salary based remuneration and patient co-payments) are acknowledged. However we must undertake a fresh careful examination of the various funding arrangements in the light of changing circumstances. For example growth in health expenditure, changing expectations of Generation X and Y medical practitioners (wanting to work fewer hours and without the additional "hassle" of the running of a small business etc) and improvements to clinical decision making processes (eg promotion of evidence based practice) are all factors that should lead us to reconsider the role of salary based remuneration arrangements. Efforts should also be made to ensure consistency of approach between the various health professional groups. For example, nurse practitioners, midwives and many other health professionals are not able to obtain a Medicare provider number under the MBS. Recently some changes have been made regarding new item numbers for services provided by practice nurses (not to be confused with nurse practitioners) in GP surgeries (for the provision of immunisations, wound management, performing pap smears etc) but claims for such items **can only be made by a medical practitioner** and rebates paid to the practice and not the nurse providing the service. Other incentives are also available to practices to assist in the employment of nurses and other health workers in the general practice setting. If we are to truly examine appropriate extension of roles within the health care team then this must also involve an examination of remuneration arrangements and a consistent approach must be taken.

### **Where to from here?**

**Good regulatory practice:** We have enclosed with this submission a copy of a submission provided for the NCP review of nursing legislation in Queensland. This document outlines areas of pressing concern to the QNU (e.g. the current deficiency relating to lack of appropriate regulation of so called third level workers). In Queensland we have undertaken a review of the regulation of nursing through this NCP review, and many if not all of the issues raised as principles underpinning such a review were

considered in this review. We do take issue with the first of these principles however (that regulation should only be employed where less intrusive means of pursuing the objectives are likely to be successful) given the obvious public interest issues at stake in the delivery of health services and the role that government must play in ensuring that standards are met. That health services are not “normal marketable products” is accepted in the issues paper (Box 8 on page 40). There are obvious tensions that must be managed here, that is acknowledged, but there is a need for greater openness, transparency and consistency of approach if we are to manage these appropriately.

There are also examples of innovative practice and approaches that should be examined by the Commission. For example in 2002 the QNU and QNC jointly sponsored the development of a document (the Social Charter for Nursing in Queensland) that aims to make nursing practice more responsive to changing circumstances and situate such practice within a societal context. This document is reviewed annually. (A copy of the charter and explanatory pamphlet are also enclosed for your information.) It is essential in our view that nurses work in partnership with the community when developing and delivering health services. Mutual obligations and rights need to be clearly stated and acknowledged. Nursing and community organisations are invited to sign on to the charter and currently the charter has 155 signatories. It is for us a living document and one that places nursing and its regulation firmly within a clear framework that is reviewed (in conjunction with key stakeholders and signatories) annually.

**The use of market friendly mechanisms:** The applicability of many market friendly mechanisms to human services is highly questionable in our view. One principle – that of aiming to provide optimal information to enable sound decision making - is one that we believe should apply in this sector. But central to the process of beginning to address information asymmetry in health is addressing power imbalances and lack of openness and transparency. These are very big issues that will not be properly addressed until many significant cultural issues are addressed. In our view the necessary change could be generational. What is valued and what is measured in health are also issues that require close attention.

The final paragraph of the section of the issues paper on competition related reform in the human services area quotes another Commission study that advocated “a shift in focus of competition away from “who pays” to “who provides the best value”. It would be a great concern to the QNU if a narrow definition of “best value” is to be applied – that is, who provides the cheapest service. Any evaluation of “best value” in health care must be broad and encompass an analysis of “best outcomes”. As stated before, for too long in health there has been a narrow over-emphasis on efficiency. This often places health professionals at odds with their professional obligations to provide high quality patient centred care. This tension is central to problems of retention in the health workforce – nurses and other health workers leave the sector or decrease their hours of work (as a “survival” strategy) because they experience difficulty coping with excessive workloads that mean they can not provide the individualised care they feel duty bound to deliver.

## **Reform in other areas**

We strongly agree that the area of superannuation policies and the current retirement incomes system in general need to be considered carefully if we are to encourage workforce attachment for health workers given our specific demographic challenges. This must also include an examination and implementation of other strategies aimed at encouraging health workers to stay in the workforce such as access to appropriate part time employment arrangements and the implementation of reasonable adjustment policies for older workers. Again cultural issues will be central to achieving progress in these areas – current overt and covert discrimination against older workers must be addressed.

## **Facilitating the reform process**

We agree that all of the issues highlighted in this section of the issues paper will need to be addressed if the reform process is to be successful.

## **Issues flagged by QNU in previous submission to this inquiry**

In our April 2005 submission to this inquiry the QNU flagged a number of issues that we believed were of relevance to this inquiry. Many of these issues are dealt with in greater depth in the enclosed submission to the Systems Review of Queensland Health. We will however briefly expand on each of these issues now. (The dot points contained in our initial submission have been extracted below.)

- **current inadequacies and inconsistencies with regard to the way in which work is valued in the health sector and the failings of our current systems (industrial and professional) to appropriately deal with this issue. This is linked with the manner in which productivity is assessed in the health sector and the undue emphasis placed on meeting efficiency indicators, and insufficient attention to issues of effectiveness and quality of care. The failures of enterprise bargaining in the health sector will also be addressed in our submission;**

The issues of inconsistencies in the approach to work value, the problems arising from an over-emphasis on efficiency and the failure of enterprise bargaining processes to appropriately reconcile industrial and “professional” agendas in the health care sector are addressed in some detail in the enclosed submission to the Systems Review of Queensland Health. (Please refer to that submission for further details.)

In this submission we argue strongly for the adoption of a new approach to enterprise bargaining in health and the better integration of processes that relate directly to outcomes in health care. Why is it, for example, that there is a separation between “quality” and enterprise bargaining processes when it is so obviously the case that the

endeavors of health workers in the quality arena contribute to better performance/improved outcomes in health and therefore should be captured in processes that determine remuneration for health workers. Nurses and other health professionals are “knowledge workers”. As such it is essential that their activities under the guise of the multiplicity of agendas in health are captured and measured appropriately.

Our experience to date with enterprise bargaining in health is that a narrow efficiency focused agenda is adopted by most employers. In most instances this has resulted in cost containment but the process and outcomes prove to be unsatisfactory ones for health workers. The workplace reform that has occurred in the health sector in the last decade or so has been significant as have the efficiencies gained through this reform. The QNU does not oppose much of the reform that has taken place in recent years. Far from it, technological advances in health care have resulted in better outcomes for patients and more efficient use of health resources. What we do oppose however is reform for reforms sake and the over-emphasis that has been placed on efficiency based reforms. We firmly believe that across all sectors in health an undue emphasis on narrowly defined efficiency indicators rather than adopting a balanced approach to measuring performance in health that incorporates indicators of effectiveness (including quality) and access. This over-emphasis on efficiency gains and maximising health service budgets promotes dysfunctionality and cost shifting within health that can threaten appropriate quality patient care. The QNU strongly believes that we need to adopt a new approach to bring about a balance in the system is a genuine partnership approach between health service providers, their employees and their unions and patients/clients.

This can be done and must be done. We started down this track some years ago now in Queensland Health. Under the first Enterprise Bargaining Agreement with that agency a shift in emphasis was to occur towards a partnership between Queensland Health as employer, its employees and health unions who represent the interests of their members in Queensland Health. This partnership necessitated a level of trust that was evidenced by the provision of meaningful information at the regional, workplace local consultative committee level and the central consultative committee levels. Initially meaningful information about issues such as activity, staffing and budgets was relayed that facilitated examination of key issues of concern in order to plan strategies to address these. The necessary flow of information soon ceased, due in large part to the internal and external political sensitivities of the health portfolio. The “best practice” approach that the parties had agreed to implement was quickly replaced with a short term negative cost cutting (“cheap practice”) approach. Queensland Health’s reluctance to disclose meaningful information continues to this day, with the QNU being forced to utilise Freedom of Information legislation (unfortunately unsuccessfully) to attempt to obtain information on budget allocations at the District and facility level.

A Best Practice approach was promoted by all parties because it was acknowledged at the outset that health was different to other industries and for enterprise bargaining to succeed in this sector there needed to be a different emphasis. The emphasis needed to be placed on cooperation not competition and rather than the emphasis being merely of efficiency an equal emphasis needed to be placed on effectiveness and quality. Such an

approach was the only way that we could see that enterprise bargaining could work in health. The outcomes produced in health are not like “widgets” produced on an assembly line – in health our outputs are at times nebulous and much more difficult to measure directly.

The best practice approach to enterprise bargaining was abandoned by Queensland Health in their second Enterprise Bargaining Agreement – replaced by a framework where pay outcomes were linked to the achievement of efficiency outcomes. But the best practice approach was retained by the agency under the guise of its Quality Improvement and Enhancement Program (QIEP) and other programs such as the Clinician Development Program and now ISAP (Integrating Strategy and Performance programme). There was a huge problem with this separation though. Effectively this agenda has been taken out of the industrial arena and situated in the “quality” area. As such, the outcomes achieved in this area are not appropriately captured and as a result there is a fundamental failure of the contribution of nurses and other health workers to be measured and rewarded appropriately.

Enterprise Bargaining has been the vehicle for health reform in the last 10 years. In our view EB has failed both the health sector and nursing – but it is the only way we can achieve pay increases for members. We argued from the outset that it would be problematic to implement EB in the health sector but lost that argument. We have a number of reasons for saying this:

An adversarial wage fixing system based on industrial conflict is counter productive in a system where cooperation and teamwork are central to achieving outcomes. Trust is easily destroyed and hard to rebuild.

It is not appropriate to strictly apply market principles in health given that it is not a perfectly competitive market. The health system does not meet the criteria of the theoretically “perfectly competitive” model in a number of ways.

Efficiency outcomes are more difficult to measure in health and are merely one indicator of success, effectiveness and equity being the other two areas where indicators are in the process of being developed.

The lack of access to meaningful information in the health sector both public and private remains a significant impediment to appropriate health workforce reform that must be addressed as a matter of urgency. There is a need to adopt a genuine partnership approach to workplace reform in health and access to meaningful information is central to this.

The bargaining power of nurses is inherently limited because of the nature of the work performed. It is harder for nurses to take industrial action and they always do so reluctantly. But nurses have done so in recent years in an unprecedented fashion. The emphasis during industrial campaigns is to find creative forms of industrial action that embarrass or inconvenience employers rather than have a

direct and sustained impact on patient care. When action such as bed closures that limit services is taken it is not done so lightly and is on the basis of maintaining safe levels of care.

The health system is complex and inherently political. Long standing entrenched power imbalances complicate rational functioning of the system. The reluctance of government (of all political persuasions) and employers in the private sector to address the inherent power imbalances that would bring about far reaching reform is a fundamental problem.

The outcome sought in many areas of health is not the maximisation of profits through efficiency or productivity gains as it is in other sectors. (The exception is of course the “for profit” health sector.) Instead the aim is to perform more services within an allocated budget or to stay within budget. (“Fiscal gate keeping”.) This is a significant source of tension for our members – the constant push to do more with the same or less resources. Something has to give and our members are tired of basic or safe care rather than holistic care becoming the norm. This is soul destroying for nurses as is evidenced by the wastage of nurses from the system either through the cutting of hours worked or leaving the system altogether.

We strongly believe that the true value of nurses’ work was not adequately ascertained under the previous centralised wages system. The depth and range of skills of nurses have not been adequately acknowledged and rewarded and as a result gender based pay discrimination is experienced by our members. Enterprise bargaining and the decentralised industrial relations system have merely served to reinforce this disadvantage.

The complexity and richness of the work of nurses continues to be undervalued by industrial and health systems alike. Nursing is incredibly personally rewarding – nurses love nursing, it is the context of in which they work, one of budgetary constraints and insufficient resources, and their often unsafe and conflict ridden work environment that is the source of angst for many nurses. *I love nursing but hate my job* is a frequent statement we hear made by members.

The culture in health is a critically important issue that requires specific and urgent attention if we are to address the myriad of issues that impact upon appropriate health workforce planning. Focusing on structures and systems alone will not adequately address these issues – we must also turn our attention to relationships and power imbalances.

- **workload management in the health sector and the nexus between workloads and patient outcomes and how we can best ensure safe staffing levels;**

Workload management is a vitally important issue for our members and is always at the top of the list of issues that our members identify as needing to be addressed in enterprise bargaining negotiations. The 2001 and 2004 research by USQ (enclosed) confirms our

experience. Nurses are well aware of the nexus between adequate staffing and appropriate skill mix and patient outcomes. In recent years international research has indicated the clear link between these matters. Current research being undertaken in New South Wales will shed more light on these issues in an Australian context. (This is the \$1.2 million *Nursing workloads, skill mix and patient outcomes study* at University of Technology Sydney established in 2003 through funding from the New South Wales government.)

Queensland nurses are also well aware of the nursing staffing differences between states. This awareness has become more acute since nurses in Victoria secured a 1 to 4 nurse to patient ratio in most Victorian public hospitals in 2001. The data extracted from Report on Government Services 2005 demonstrates the difference in staffing numbers of the various occupational groups employed in public hospitals in Queensland compared to the Australian average.

**Extract from Table 9A.7 Average Full Time Equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) 2002-2003<sup>3</sup>**

Category of Staff	Qld	Aust Average
Salaried Medical Officers	0.9	1.0
Nurses (all registered and enrolled)	3.9	4.3*
Other personal care staff	0.2	0.1
Diagnostic and Allied Health	0.9	1.4
Administrative and Clerical	1.2	1.6
Domestic and other	1.7	1.5
<b>TOTAL</b>	<b>8.7</b>	<b>9.8</b>

*(Totals do not add up - reproduced as presented in table)*

In Victoria the number of nurses per 1,000 population is 4.5. This is a significant difference. Resident population for 2003-2003 financial year (i.e. as at 30 June) was 3764000 for Qld and 4894000 for Vic. And the number of nurses employed in Queensland public hospitals can therefore be calculated as 3764 x 3.9 for Qld = 14679.6 FTE and 4894 x 4.5 for Vic = 22023 FTE. To bring Queensland public hospitals to the nurse staffing levels provided in Victorian public hospitals would require an additional 2258.4 FTE and to bring Queensland to the national average in terms of nursing staffing an additional 1505.6 FTE positions would be required. Note, NSW data was not provided

<sup>3</sup> Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9.A.7*, Canberra.

for 2002/2003, but according to data provided for 2001/2002 there were 4.5 nurses employed in public hospitals per 1000 population in NSW in that year.

Nurses and other health workers are extremely angered by discrepancies of this nature. The overemphasis on efficiency in states such as Queensland has resulted in the containment of staffing numbers. To date there has not been any attempt to measure the effect of this on quality of care or patient outcomes in this state. It is essential that this occurs. The time has come for a holistic approach to the measurement of performance in health. This is anticipated by the performance indicator framework that has been devised for publications such as the Report on Government Services but is far from becoming a reality.

- **current significant skills shortages in health (especially in nursing) and the failure of governments at the state and federal levels to adequately address these shortages;**

Although the latest Nursing labour force report (*Nursing and Midwifery labour force 2003*) from the Australian Institute of Health and Welfare (AIHW) indicates an improvement in nursing supply, shortages still exist in all areas of nursing specialty. The AIHW data requires closer analysis in our view. The increase in the number of employed registered and enrolled nurses in 2003 could have been affected by the employment blitz that occurred in Victoria to implement their 1 to 4 nurse patient ratio. (This blitz attracted an extra 4000 nurses back into the Victorian public health system.) We believe that at this stage it is too early to make the call, as AIHW did in its media release when this publication was released this month, that this could '*signal a reversal of the downward trend in nursing supply recorded in recent years*'.

The Departments of Workplace Relations (DEWR) skill shortage survey (conducted in October 2004), identified that shortages exist nationally (and in Queensland) for all nursing categories. That is for the categories of:

- Registered Nurse  
Accident/Emergency  
Aged Care  
Cardiothoracic  
Community  
Critical/Intensive Care  
Indigenous Health  
Neonatal Intensive Care  
Neurology  
Oncology  
Operating Theatre

Paediatric  
Palliative Care  
Perioperative  
Rehabilitation  
Renal/Dialysis  
Registered Midwife  
Mental Health Nurse

- Enrolled Nurse

With regards to other categories of health workers national shortages exist for the following categories (and all of the categories below in Queensland except for podiatrists):

- Dentist
- Pharmacist (Hospital/Retail)
- Occupational Therapist
- Physiotherapist
- Speech Pathologist
- Podiatrist
- Diagnostic Radiographer
- Radiation Therapist
- Nuclear Medicine Technologist
- Sonographer

The issues paper highlights a significant shortfall in the DEWR skill shortage analysis process, that doctors are not included in their analysis. It is our understanding that this limitation is not one created by DEWR, but rather that the issue of medical labour force is not included in their remit from government as doctor numbers are subject to separate policy considerations through the Commonwealth Department of Health. The fact that doctors have recently been included on the MODL despite not being monitored via the DEWR skill shortage analysis is an indication that serious shortages exist. The time has come in our view for doctor numbers to be subject to the same degree of analysis and scrutiny by an independent department with specialist labour market analysis skills as other categories of health workers. They cannot be treated as in some way “special” or “outside” the health labour force. This is not to say that because such independent analysis by DEWR occurs that government will pay appropriate attention to it – government at the state and federal levels have largely failed to adequately address the nursing shortage for years. However having one consistent and coordinated labour force/skills shortage analysis tool for all health workers is in our view a prerequisite for appropriate health workforce planning.

It is recommended that:

One consistent health labour force skills shortage measurement tool be established for all health workers. This can be achieved through the inclusion of doctors in the DEWR skill shortage analysis tool and making any necessary modification to this tool to accommodate this inclusion.

Research published in a recent edition of the MJA on “baby boomer” doctors and nurses that was referred to earlier in this submission clearly highlights that significant demographic challenges exist and that a range of strategies will need to be employed to encourage workforce attachment for the baby boomer and subsequent generations. These strategies will need to be multilayered and targeted and must include an examination of the nexus between the superannuation and retirement incomes systems and the health workforce. The development of such strategies cannot occur in isolation and such a process must be both ongoing and adequately resourced. It is unfortunate that a Work and Family Taskforce established some years ago in Queensland that addressed many of these issues has never formally reported to government nor its findings made public. In our view a process like this is required for the health workforce.

It is recommended that:

A national health and aged care workforce taskforce be established to examine workforce shortages and develop strategies to address these. Such a group must be inclusive of all key stakeholders (including health unions). This peak body should form sub groups dealing with specific priority issues (e.g. groups should be established to address incentives to encourage labour force attachment and occupational specific issues) and develop strategies for consideration by government. It would be appropriate for like bodies to be established in each state/territory to feed in to the national process.

- **issues of skill mix and substitution in the health and aged care sectors and concerns with current inadequacies in quality assurance systems and processes;**

Issues of skill mix and substitution are of great concern to the QNU and are referred to in more detail in the attached submission to the Queensland Health Systems Review. (Please see this submission for further details.) Currently significant changes are occurring in some sectors (e.g. substitution of qualified personnel with unqualified personnel) and this is occurring in the absence of evidence to support such change, without the establishment of monitoring mechanisms to evaluate outcomes and in the absence of appropriate consultation with key stakeholders. The QNU agrees that there needs to be close examination of existing roles and role boundaries within health and expansion of roles where appropriate. But there are certain prerequisites for this to occur.

Appropriate consultative arrangements involving all key stakeholders must be established and proposed changes to skill mix and role boundaries must be based on evidence and any changes subject to rigorous monitoring and evaluation processes. It is also essential that any proposed enhancements to roles be carefully considered in context. (For example, as previously stated it is inappropriate to be contemplating wholesale implementation of nurse practitioner roles if pre-existing nursing shortages are not first addressed.) At all times the primary objective is to ensure timely access to safe, high quality, evidence based and appropriate health services for the community.

The QNU would also like to place on record its opposition to the creation of a “new” breed of rural health workers as reported in an article in The Australian (“Radical plan for doctor-nurse hybrid”) on 23 July 2005. It is highly inappropriate for the courses for such health workers to be provided through the TAFE sector. In our view more emphasis must be placed on facilitating the implementation of nurse practitioner positions and making sure that both doctors and nurses in rural areas have appropriate support. Please see the submission by our national body the Australian Nursing Federation for more information on problems with the models being proposed.

- **inconsistencies in health worker education in Australia and who bears the cost of this at present, especially with regard to post graduate studies and how this contributes to skills shortages. (For example, the differences in costs and arrangements for nurses undertaking post graduate studies compared to doctors);**

This issue has already been discussed earlier in this submission – please see previous comments recommendation made regarding this issue as well as relevant sections of the QNU submission to the Queensland Health Systems Review.

- **the need to significantly change the culture and power relationships in health in order to aid recruitment and retention of personnel and encourage genuine “consumer” involvement in health planning and decision making;**

This issue receives considerable attention in our submission to the Queensland Health Systems Review so please refer to that document for more information. The importance of addressing cultural issues and power relationships in health cannot be overstated in our view. Although such matters may fall outside the particular expertise of the Productivity Commission (which is more accustomed to dealing with “hard facts” and matters with an economic focus rather than often intangible matters pertaining to relationships) we believe that it is critical that existing deficiencies in these areas be addressed.

- **significant issues with respect to health and safety (and the impact on workers compensation) and other issues related to providing a safe and supportive workplace environment for health workers;**

The health workplace is an inherently dangerous one – health workers deal daily with diseases and dangerous substances to treat them and in an environment where workplace violence is unacceptably high. The nature, sources and extent of the violence encountered by health workers is highlighted starkly in the enclosed USQ report (For example, over 50% of all respondents to this survey reported that they had been subject to workplace violence in the previous three months.) Please refer to the section on workplace violence in the enclosed report for more detail. The workplace environment must be made safer – there is an imperative to ensure the safety of staff and clients alike. Focusing on improving workplace health and safety would also result in significant cost savings as well.

We have recommended in our submission to the Queensland Health Systems Review that particular attention be paid to the area of workplace health and safety – please see that submission for further details. This is of particular importance given the ageing of the health workforce. Health issues for older workers will have to be managed if we are to encourage their workforce attachment. Unfortunately it is still our member’s experience that they continue to be treated as a “disposable” workforce by some employers, despite the nursing shortages. Some employers are very eager to forcibly retire nurses medically unfit (rather than redeploy them to other appropriate duties) after they have sustained an injury in the workplace or suffered a non-work related illness. It is essential that matters such as reasonable adjustment policies and other strategies to address workplace health and safety concerns for an ageing workforce be addressed in order to have a holistic approach to health workforce planning.

- **the potential impact of demographic challenges on the health workforce and demand for health services;**

This issue has already been addressed earlier in this submission, as well as in other materials that are enclosed. The Commission is well aware of the significance of this issue.

- **the need to review current remuneration arrangements for health practitioners (such as the fee for service funding arrangements for medical practitioners);**

Again, our concerns regarding this issue have already been outlined earlier in this submission.

- **the differential treatment of health workers with respect to government assistance for professional indemnity insurance;**

As the Commission would be aware, the federal government has provided significant resources to secure medical indemnity arrangements in recent years. The same level of assistance has not been extended to other health professionals. However particular problems exist for other categories of workers such as independent practitioner midwives (those who are not directly employed) and we anticipate there could be issues for nurse practitioners if they are not directly employed. We offer professional indemnity insurance to our members as part of their membership fee but this insurance only covers those who are directly employed – it does not cover independent practitioners. We are advised that the cost of securing professional indemnity insurance for health professionals such as independent midwives is extremely prohibitive. Developing and implementing a consistent approach to matters such as indemnity insurance will be essential if the development of new and expanded roles is anticipated. One category of independent practitioner cannot be singled out for more favorable treatment than others. The current indemnity insurance arrangements effectively preclude the expansion of other independent health worker roles due to the prohibitive cost of insurance for these workers.

- **the need to promote innovation in models of health care such as multi-disciplinary primary health care teams and the role of nurse practitioners in these and other settings;**

There is no doubt that there is a great need to embrace new models in health care if we are to adequately address current health workforce concerns. The need for a new approach and pre-conditions required for this to occur appropriately are outlined in the attached QNU Submission to the Queensland Health Systems Review and we recommend that you refer to that document for further information on this topic.

- **lack of a coordinated, adequately resourced and nationally consistent framework for health workforce planning – the lack of political will to address this issue is of grave concern.**

This obvious shortcoming has in large part been the impetus for the current Productivity Commission inquiry. In our view, many of the solutions to the problems at hand are well known – all that is required is the political will and resources to implement them. As recommended earlier, there is a need to establish coordinated national and state consultative arrangements to facilitate this. A significant change in culture and a commitment to openness, transparency and consistency of approach will also be required if we are to successfully overcome existing problems. Again, issues pertaining to workforce planning are canvassed in the attached QNU Submission to the Queensland Health Systems Review and we recommend that you refer to that document for further information on this topic.

Thank you again for the opportunity to provide feedback on the issues paper for this important review. Please do not hesitate to contact me (on in my absence QNU Project Officer Beth Mohle) should you wish to discuss any issues raised in our materials or if you require any additional information. As stated previously, we would be happy to arrange a meeting with researchers from the University of Southern Queensland, officials of the QNU and officers of the Commission should you wish to discuss the *Nurses. Worth listening to.* report further.

Yours sincerely,

**Gay Hawksworth**  
**SECRETARY**

## 1. Introduction/Review Background

### 1.1 Purpose of the Review

In our previous submission to this review of the *Nursing Act 1992* the Queensland Nurses' Union (QNU) outlined our general serious concerns about the appropriateness of applying National Competition Policy (NCP) principles in the health sector. We wish to reiterate some particularly important aspects of these concerns again and also delve more deeply into the notion of the application of competitive market principles in health generally and in particular to the practice of nursing.

Firstly, the QNU rejects the assumption inherent in the competitive model – namely that competition in itself is always a worthwhile objective in its own right. In this model competition is an unquestioned virtue, one that assumes paramount importance in its own right. The QNU is particularly concerned that the implementation of NCP has been driven by economic imperatives at the expense of social welfare considerations and the notion that competition will in itself lead to increased efficiency. The assumption appears to be that both competition and efficiency are always intrinsically beneficial and socially desirable objectives. The flaws of these assumptions are apparent in a number of sectors where NCP has been applied.

The application of the competitive model in a sector such as health must be done with extreme caution and on a case by case basis given that it is *“in the health sector where we almost certainly encounter the most complex market conditions in the economy.”* (Watts J, 1.15) The problems of applying a narrow competitive model in health have received considerable attention in the discipline of Health Economics.

There are difficulties associated with applying competitive models to health generally. We will highlight some of these difficulties. It is then important to highlight how nursing differs from other health professions, and in the process expose that these issues have not been given appropriate attention to date in the debate around the application of competitive principles to nursing.

In theory perfectly competitive markets are based on four assumptions that: there are many independent firms and consumers in the market, all firms are producing identical products, firms can enter and exit the market freely and both firms and consumers have “perfect information”. (Pindyck and Rubinfeld, p 283-284) In reality perfectly competitive markets rarely, if ever, exist. It is obvious that “market” in health fails to meet this model in many ways. This is due to factors that are intrinsic to health. For example, in health care markets “perfect information” is particularly problematic, as “information asymmetry” is inherent in the transactions that occur between providers and consumers (as indeed it is in the provision of professional services generally).

Sources of “market failure” in health are many and varied and require government intervention in health markets. The sources of market failure that are intrinsic to health are summarised by Watts (p2.4-2.6). She highlights that these relate to issues such as externalities, the need for the provision of public goods (and hence why

public monopolies in such instances may be more efficient), quality assurance and the need for protection of the community, the complexity of the relationship between health and the consumption of health services, the provider as agent, moral hazard and supplier induced demand and adverse selection. It is not appropriate or necessary to explore all these issues in detail now. It is suffice to say that the health market is significantly different to other markets and it has its own inherent complexities. This in not an argument for not examining the health system, rather we question the appropriateness of applying such a theoretical model in an uncritical manner.

There are many sound reasons why it is not appropriate to apply competitive principles in an industry such as health. The QNU believes that maximising outcomes (and efficiency) in the health “industry” is largely predicated on cooperation between all players, not competition. Most importantly in our view are the moral or ethical components to “transactions” in health. Because of this it is not possible to reduce transactions in health to the status of transactions that occur in the marketplace. Instead what may require analysis is not whether the health system, the legislation that governs it (including regulation of the professions) and the practices in the health system “survive” an analysis under NCP principles but rather whether it stands up to ethical analysis. Maybe more tools are required that facilitate ethical analysis, not economic analysis. An examination of one important feature of health, the nature of information asymmetry highlights these inadequacies.

Information asymmetry results in the provider of health services acting as the agent for the consumer. The complexity of and difficulties associated with this agency relationship are often not acknowledged, especially when it is the case that the agent has a vested interest in the advice/service being given. This is especially the case where a fee for service arrangement exists. Such arrangements are not an established feature in nursing. Indeed this is a significant issue that needs to be highlighted as part of this review.

Nursing differs from other regulated health workers such as many doctors and dentists and some allied health professionals where a fee for service arrangement exists and the profession sets the fee schedule. Very few, if any nurses operate under a “fee for service” arrangement. (It is also important to remember that not all doctors, dentists and allied health professionals operate under such arrangements.) Remuneration arrangements for nurses are established under the auspices of independent industrial relations tribunals. Direct employment by a government department or health agency is the normal employment arrangement for nurses. This is also the case for the emerging Nurse Practitioner role in Australia.

Some may argue that the absence of a “fee for service” arrangement means that nursing does not meet the strict definition of a profession. We wholeheartedly reject this assertion. Nursing in Queensland is self –regulated through the Queensland Nursing Council, is based on a significant body of technical expertise and is governed by a code of conduct. To us, fee for service arrangements that characterise some other health professions are not inherent to the nature of professions. They are indeed a potential source of conflict for ethical professional practice given the nature of transactions that occur between provider and consumer, particularly given the information asymmetry (and hence power imbalance) that exists. Such arrangements may have developed over time to become a feature of some professions. It is even

possible to argue that such fee for service arrangements are encouraged by or are in part a result of the power imbalance (information asymmetry) that exists between the provider and consumer. In summary, remuneration and associated issues (such as the control of the supply of professionals in order to affect the supply of such services) may result from an abuse of “market power” (and institutionalised power) but are not inherent features of professions.

We are labouring this point because we believe that this is an important issue and one that has not received enough attention to date. Nursing differs from other professions that may have abused their market and other forms of power in the past. Nurses do not set their own fees, we do not place onerous limitations on entry into specialty areas (indeed we are currently doing all within our power at present to ensure that the critical shortages that exist in nursing specialties are addressed as a matter of urgency) and we can not be accused of supplier-induced demand. We believe that we can justify the regulation of nursing in the name of public interest – such protection is required to protect not only the sick but the health of the community in general. In our view the benefits of such regulation far outweigh the costs. We also believe that the objective of the *Nursing Act 1992*, “to make provision for ensuring safe and competent nursing practice”, can only be achieved by “restricting competition”. That is, the safety of the community can only be assured by regulating nursing practice and those who can undertake it.

Our fear is that the assumption is that nursing operates in the same way in which other professions that indulge in so-called “anti-competitive” (some may prefer to use the term “unethical”) behaviour. This demonstrates a fundamental lack of understanding of the health system and the manner in which the professions who work in that system operate. In our view this review and in the general debate on the application of NCP to health, the complexities of the health context and power imbalances (not only between consumers and providers but also between the various providers in the system) have not been adequately acknowledged.

The Australian Competition and Consumer Commission (ACCC) has made no secret of the fact that they are paying particular attention to “anti-competitive” behaviour on behalf of the professions. There has been considerable media attention given to the ACCC’s view on actions of some professions in health, most notably medical specialists. We contacted the ACCC in the course of formulating this submission and asked whether they had shown any particular interest in the regulation of the nursing profession and whether they had an understanding that nurses do not operate under a “fee for service” arrangement nor is the profession involved in setting their fee schedule. We were advised that little, if any consideration has been given to nursing to date. Given that nurses make up the largest single professional group in health we find this quite astounding. We are concerned that this indicates a fundamental lack of understanding of the way in which the various professions operate within the health sector. We are also concerned that a rather uncompromising approach may be taken to all health professions. Has the ACCC clearly identified the types of behaviours that they consider “anti-competitive”, who is involved in this, quantified the impact of this behaviour and then examined all possible avenues for remedy?

In a recent speech to the Centre for Health Program Evaluation at Monash University, Professor Allan Fels outlined the ACCC’s concerns about how the professions are

affecting the efficient delivery of health care in this country. In this speech he highlighted some valid and longstanding issues of concern that need to be publicly examined and debated. Near the end of his address (Fels, p 20) he made an important contextual differentiation:

*“I believe that professionals, including doctors, and lawyers, and dentists, should be treated no differently to others engaged in supplying services and goods to the public and who choose to operate as businesses.”* (emphasis added)

If regulatory frameworks exist that are acceptable to both the community and the professions and ensure ethical behaviour (even when a professional chooses to operate as a business) then would it be necessary to apply an economic framework to address behaviours that negatively impact on the common good? Is it the case that the actions of a few may have called the actions of all into question? What are the implications for those professionals who do not act as businesses? The application of theoretical economic dogma will not address these issues that essentially relate to power imbalances and ethical behaviour. Central to addressing these concerns is access to meaningful information by consumers that enable informed choice and mechanisms to address, as far as is possible, power imbalances in health. This is a significant agenda. The NCP review processes of the professions may highlight issues of concern but we believe that the remedies required are the responsibility of government, as elected representatives of the community, not the market.

Governments determine that such regulations are necessary in the interest of public safety. Some argue that regulation of this nature provide unnecessary barriers to competition. The alternative view is that such minimum regulations are required to be set by government because the market, left to its own devices, will not ensure the public good. There are costs to both government and private health care providers associated with the administration of such regulatory frameworks but there are also obvious benefits as well. Government, on behalf of the community as a whole, conducts analyses of the costs and benefits of such regimes and legislates and administers accordingly.

We are pleased to see that the current government has moved away from an unquestioning approach to the NCP. The Queensland Treasury document titled *Public Benefit Test Guidelines: Approach to undertaking Public Benefit Test Assessment for Legislation Reviews under National Competition Policy* details the change in the government’s approach to such reviews. This document details (at p 6-7) the undertakings given under the Competition Principles Agreement (CPA) that:

*“ ... legislation should not restrict competition unless it can be demonstrated that:*

- *The benefits to the restriction to the community as a whole outweigh the costs;*
- and*
- *The objectives of the legislation can only be achieved by restricting competition*

*This means that NCP reviews must not only consider whether an existing/proposed restriction provides a public benefit, but also whether other options would achieve a greater public benefit.”*

The last sentence of this quote highlights an important point that is relevant to the current review of the *Nursing Act 1992*. The November 2001 Discussion Paper highlights some examples of potential inadequacies of the current regulation of nursing practice in Queensland. A number of issues highlighted in the discussion paper are also of concern to the QNU, and were highlighted in our previous submission to this process. The first relates to the need for the Queensland Nursing Council to regulate those people who are currently not regulated by the council and yet are carrying out nursing practice (at times without the supervision of registered nurses). The second issue highlighted in the discussion paper is the need for a clear and concise definition of “nursing practice”(that is suitable for legislative purposes). This second issue is perhaps more difficult to address than the first. However, in our view attempts should be made to improve the current legislation so as to strengthen the benefits to the community. Although this may not be possible through a legislative definition other avenues to address this issue need to be investigated as a matter of urgency. (Our interpretation of “other options” includes the strengthening or clarification of current provisions, not the replacement of regulation with other forms so called “regulatory alternatives”.)

Another important point made in this Treasury document is found in a following paragraph (p 7):

*“The need to carry out the review of legislation recognises that government regulation can sometimes create unwarranted barriers to entry or other restrictions on business which limit consumer choice, stifle innovation and reduce incentives for achieving better efficiency. **However, the review of legislation does not imply a need to introduce or ensure competition for its own sake nor imply that competition objectives should take precedence over other important public policy objectives.**”*  
(our emphasis)

This is a critically important shift in policy approach by the Beattie government that is welcomed by the QNU. A fundamental criticism that the QNU has of past application of NCP has been that too often competition for competition’s sake has been an overriding objective, at the expense of other equally (or more) important objectives such as equity, access and effectiveness. Under the nationally consistent approach to the annual reports on government service provision includes the need for the development of indicators to measure such outcomes. (See *Report on Government Service Provision 2001*.) However, to date undue emphasis has been placed on the development of indicators to measure efficiency. A number of efficiency (unit cost) indicators have been developed for public hospitals, (eg Recurrent cost per casemix adjusted separations, Labour costs per Casemix adjusted separations, User cost of capital per Case mix adjusted separation, Casemix adjusted relative length of stay and under development is the indicator Cost per non-admitted occasions of service). However, work on developing effectiveness indicators (covering areas such as quality, appropriateness and accessibility and access) has for too long been wanting. In our view indicators of outcomes that are not related to efficiency outcomes in health are an integral part of the PBT assessment of legislative reviews affecting the health sector. Until such time that these are developed it would be inappropriate to base decisions on whether legislative changes are warranted until such time that these are developed.

Further to this, the Queensland Treasury document states (p 8) “*that the combined effects of the costs and benefits to the community must be assessed against the Government’s Priority Outcomes.*” These are:

- “ *More jobs for Queenslanders*
- Building Queensland’s regions*
- Skilling Queensland*
- Safer and more supportive communities*
- Better quality of life*
- Valuing the environment*
- Strong government leadership”* (p 8)

We believe that assessments of the impact of the application of NCP principles to nursing regulation has an impact in most of these priority outcome areas, therefore making this review all the more complex. Will the final Public Benefit Test document assess against all of the above criteria, and if so why haven’t those making submissions to this review been requested to make comment on these to assist the formulation of the PBT report?

It is also important to remember that there is a broader context to consider. All of the issues of concern that we have raised in this section highlight the complexity of applying a competitive model used in the “trade of goods” to the “trade of services”. This debate is of international significance given the undertakings given to date by the Australian government to international bodies such as the World Trade Organisation (WTO) in the current round of General Agreement on Trade in Service (GATS) negotiations.

Finally, as part of this review process it is essential to revisit the original objectives of the *Nursing Act 1992*. These must be kept at the forefront of this review process. The objective of the act is: “*to make provision for ensuring safe and competent nursing practice*”. Further exploration of this issue can be found in the second reading speech of the Bill by the then Minister for Health, Hon Ken Hayward. This stated in part:

*“Although it is true that regulation of a profession is a benefit to the members of that profession – a benefit which accrues by virtue of status afforded through Government recognition, and in being able to self-regulate – the main purpose of such regulatory activity is of increasing importance today to both the public and the Government. That purpose is if course, consumer protection. Hence the objective of the Bill explicitly refers to “ensuring safe and competent nursing practice. I believe that the role of regulatory bodies such as the Queensland Nursing Council, will expand, particularly with the Health Rights Commission becoming operational from 1 July 1992, so as to eventually provide a fully integrated consumer protection system in Queensland.” (Hansard, 5 November 1992, p 78)*

He concluded this speech by stating:

*“This Bill is a progressive piece of legislation. It is one which makes provision for the many changes that are occurring in nursing, and it does this in such a way that I see certain features of it acting as the model for review of legislation governing other professional registration boards under my portfolio. I commend the Bill to the honourable members of this House.”* (Hansard, 5 November 1992, p 80)

From these Hansard extracts it is apparent that the overriding concern of the government at the time was consumer protection. This must remain the overriding concern of the government of today during this review process. It is also apparent to the QNU that the Health Minister at that time saw this legislation as a “model” for legislation governing other health practitioners. At the same time he envisaged the strengthening of consumer protection through other related reforms (eg through its relationship with legislation governing the Health Rights Commission). Whether this strengthening of consumer protection has indeed occurred since 1992 must be considered as part of this review, as should how effective other related bodies such as the Health Rights Commission have been at achieving this critically important objective.

## **1.2 Review Process**

Although we acknowledge and welcome the shift in the state government’s approach to NCP, we do however remain concerned about a number of critical issues. These include the threshold issue of “onus of proof” that underpins NCP, how reviews are conducted and the adequacy of tools available to quantify costs and benefits.

A basic tenet of NCP is that competition is beneficial and only in instances where it can be clearly demonstrated that competition is “not in the public interest”, are exemptions to be granted. In our opinion, particularly in the area of the provision of essential services by government, the opposite should apply. NCP should only be implemented in areas where it can be clearly demonstrated that competition is in the public interest, that is, “onus of proof” should be reversed. This concern has in part been addressed by the Beattie government’s new approach to NCP reviews. The issue of how reviews are conducted is still of concern.

The QNU believe that government must always conduct NCP reviews. They are so important that the government must have confidence in and remain totally accountable for all such reviews. We are pleased that the review of the *Nursing Act 1992* has remained “in-house”, however the same can not be said of the review of legislation that covers other health professionals. The consultancy firm Price Waterhouse Coopers is conducting this review. We have written to both the Premier and Queensland Health to express our concern about this issue as well as our concern about consistency of approach in reviews. The Premier has responded to our concerns regarding review processes, providing us with a copy of Queensland Treasury’s Public Benefit Test Guidelines. The fundamental principle relating to the appropriateness of transference of responsibility for conducting reviews to corporations has however not been addressed to our satisfaction. We stress again that is our view that government, the elected representatives of the community, must be

responsible for the total carriage of all such reviews. How it is determined whether reviews should be considered “minor” or “major” reviews is also of concern. The review of the *Nursing Act 1992* is considered a minor review but it is debateable whether this should be considered a major review (and therefore be the subject of more robust PBT assessment) given the significant potential for adverse health effects should barriers to practice nursing be weakened or removed. The determining factor appears in part to the availability and adequacy of tools to quantify the impact of change.

This brings us to our final issue of concern, whether sufficient robust tools currently exist to accurately estimate the economic and social impacts of any proposed regulatory change. Quite often such impacts are impossible to accurately quantify. This is particularly the case when assessing such impacts in a complex area such as health. We believe that when there is any doubt then the government must err on the side of caution and determine not to de-regulate. Econometric models alone can not predict all costs and benefits in a PBT assessment. The effect of the de-regulation of health professions on health outcomes and quality of care for the community is difficult to fully quantify. Such analysis has only fairly recently begun to occur in some areas. For example, an increasing body of US research is demonstrating “*that increasing levels of qualified nursing staff impact positively on broad indicators such as length of stay and mortality rates, as well as adverse events such as nosocomial infections.*” (Chiarella and Crisp, p 6)

We have a number of other concerns that we wish to highlight about the review process to date. Firstly, we are concerned that only 27 submissions were made to the initial call for comment advertised in March 2000. We believe that this is an inadequate response and remain particularly concerned that the views of consumers may not have been adequately obtained to date. This second call for submissions is therefore very welcome. With respect to this though, we are concerned about the timing of this second part of the process, given that further submissions were called for at the end of November 2001 and are due by 28 January 2002. We are concerned that the intervening Christmas period will result in a decreased response rate. The QNU, for example, has not been able to adequately consult with our membership due to the timeframe for comment. Other bodies and individuals (eg nurse academics) may also not be provided with adequate time for consideration of these issues given that many institutions “close down” for protracted periods over the Christmas break.

Another issue of concern is that the QNU and other organisations/bodies that represent the collective interests of nurses are not specifically mentioned in the list of key stakeholders contained on pages 5-6 of the discussion document. Individual clients, nurses and midwives, nursing support workers, the QNC, organisations that provide health services and employers are all mentioned but not the QNU (or other nursing organisations). This may be merely an oversight, but even so is of significance. As a representative of over 28,600 nurses in Queensland, the QNU is a significant stakeholder in this process. Given that NCP has been widely interpreted as being part of a wider ideological agenda that promotes the primacy of the marketplace and individual players in it at the expense of collective or social goals, this is a worrying oversight that may only serve to reinforce this perception.

For further explanation of our overriding issues of concern about the ideology underpinning NCP and its application to the health sector generally and nursing specifically also refer to section 1.1 above and our previous submission to this process.

## **2.0 Industry Profile of Nursing and Midwifery**

### **2.1 Industry Profile of Nursing**

#### **2.1.1 The Role of Nurses**

The International Council of Nurses defines a nurse in its constitution as “a person who has completed a program of basic nursing education and is qualified/authorised in his/her country to practice nursing” (ICN Constitution 1999, Article 6). The Australian Nursing Council Incorporated (ANCI) has published national competency standards for registered and enrolled nurses (ANCI, 1990 and 2000).

The ANCI defines the registered nurse as a first level nurse educated in degree level courses in universities. Registered nurses are licensed to practice nursing in a wide variety of health care settings and are registered to practice without supervision, assume accountability and responsibility for all their actions and aspects of care.

The Enrolled Nurse is defined by ANCI as a second level nurse who provides nursing care within the limits specified by education and the registering authorities’ licence to practice. Enrolled Nurses work under the direction and supervision of registered nurses but retain responsibility for their own actions and remain accountable to the registered nurse for all delegated functions.

In relation to the role of unregulated workers who assist with nursing work, the ICN Position Statement *Assistive or Support Nursing Personnel* states:

*“That the role, preparation, standards, and practice of assistive nursing personnel must be defined, monitored and directed by registered nurses.”*

It is important to stress that since the publication cited in your discussion paper the scope and breath of nursing practice has changed considerably. It is more essential that more recent publications on this issue are reviewed. For example, the ICN Position Statement on the Scope of Nursing Practice states that “Nurses’ spheres of responsibility include giving direct care, supervising others, leading, managing, teaching, undertaking research and developing health policy for health care systems.”

More recently, in 2001, Australia’s first Nurse Practitioner was appointed in New South Wales. Other State and Territory Governments including Queensland are currently considering the implementation of this role in their respective jurisdictions.

Further exploration of this matter can be found in the papers produced as part of the current *National Review of Nursing Education*.

### **2.1.2 Composition of the Nursing Profession**

It is of concern that in this section the unregulated nursing assistants are not recognised as contributing to nursing work. For a current exploration of the issues in this section an appropriate source would be the recently released *National Review of Nursing Education Discussion Paper*.

### **2.1.3 Education of Nurses**

There are a number of concerns to the QNU in this section. Namely:

The narrow definition of nurse education contained in the paper.

That it has been almost a decade since the transfer of nurse education to the tertiary sector and there have been significant developments during this period that are not canvassed.

There is a significant public benefit associated with the transfer of nurse education to the tertiary sector that has not been acknowledged.

The importance of improved patient outcomes associated with the employment of qualified nurses (Chiarella and Crisp research paper) has not been adequately explored.

The evolving nature of educational articulation and recognition of prior learning has not been described.

Again, these issues are canvassed well in the current *National Review of Nursing Education Research Papers*.

## **2.2 Industry Profile of Midwives**

### **2.2.1 The role of Midwives**

Please refer to the QNU's previous submission. It is noted that the discussion paper does not indicate that the views of Queensland midwives were sought during the development of the paper. As the discussion paper suggests, there is currently considerable debate in relation to the regulation and education of midwifery practice.

## **3.0 Current Regulatory Arrangement**

### **3.1 Objective**

See comments in section 1.1 on the overriding objective of the act being consumer protection.

### **3.2 Rationale for the regulation of nursing and midwifery practice**

The main rationale for the regulation of nursing and midwifery practice is the safety of the community. The issue of information asymmetry is intrinsic to health care “transactions”, and this means that government intervention is required to ensure that minimum standards exist for nursing and midwifery education and practice. The QNC is a statutory body set up under legislation and is accountable to the parliament of Queensland via the Minister for Health. That such regulation is required for nursing and midwifery (and indeed the other health professions) is widely accepted. Certainly no arguments to the contrary have been raised in the discussion paper on the NCP review of the *Nursing Act 1992*. Until such time that such arguments are explicitly detailed then we believe that the need for the regulation of nursing and midwifery practice is beyond question.

This is not to say that the current regulatory mechanisms and practices should not be subject to scrutiny. Even though the QNU rejects the ideology underpinning the NCP of nursing, this review process has been useful as it has enabled us to reflect on current practices and has afforded us the opportunity to make recommendations to improve the current regulatory framework. It is also the case that our experience of opposing employers seeking to deregulate areas of health care via the substitution of regulated nursing personnel with currently unregulated care providers highlights current deficiencies in the existing regulating framework. Over recent years we have made a number of submissions to the QNC regarding the need to regulate the “third level” of nurse. Until such time that mechanisms are put in place to facilitate determinations about what constitutes nursing practice then the community will continue to be placed at risk by those service providers who knowingly employ non-nursing personnel to perform nursing tasks. The QNU will make recommendations about potential mechanisms for improving current arrangements in the options section of this paper.

The recent trend towards de-regulation (via substitution of nursing personnel) in health is of particular concern to the QNU. The link between the provision of quality health care and numbers of qualified and regulated nursing personnel is beginning to be clearly identified in overseas research. Research conducted in the USA that was cited in a recent paper by Claire M. Fagin titled “*When care becomes a burden: Diminishing Access to Adequate Nursing*” (p 10) highlights the dangers of a de-regulation agenda in health.

*“Recent studies have shown that close to 20% of hospitalised patients have a serious adverse event during their hospital stay (Silber and Rosenbaum 1997; McGlynn, Naylor, Anderson, et al. 1994). RN- to- bed ratio was the single most important factor influencing hospitals’ differing success rates in saving patients who experienced serious adverse events, according to Jeffrey Silber and his associates.”*

The findings of other recent US research may also be of interest to this inquiry. In June 2001 in Massachusetts a long awaited report of the “*Legislative Special Commission on Nursing and Nursing Practice*” was handed down. The overarching theme of this report was contained in the covering letter to the report by its authors Senator Robert S. Creedon Jr and Brockton Representative Christine E Canavan:

*“Licensed nurses and the patients are inextricably linked. If the working conditions of the licensed nurse improve, direct patient care improves. If patients’*

*concerns for quality care are met, the working conditions for the licensed nurses have been addressed. Their relationship is symbiotic.”*

This inquiry made 6 recommendations relating to improving the working conditions of nurses in that state, including proposing legislation to limit mandatory overtime and establish patient/staff guidelines based on patient acuity levels.

Other recent research from the USA, most notably a report from the Harvard School of Public Health titled *Nurse Staffing and Patient Outcomes in Hospitals*, highlights the important nexus between nurse staffing numbers and health outcomes for patients in some significant areas. To quote from the report (p xxiv) *“In the 11 state all patient analysis, strong and consistent relationships were found between nurse staffing and five patient outcomes, urinary tract infections, pneumonia, length of stay, upper gastro-intestinal bleeding and shock”*. This study also identified strong and consistent evidence of a link between nursing staffing numbers and of “failure to rescue” on major surgical patients. This ground-breaking report recommends developments in data collection systems that would enhance further research in this important area.

It is also important to highlight that the research conducted thus far has tended to concentrate on adverse outcomes if appropriately qualified nursing personnel are not employed, not the positive outcomes that are derived for registered and enrolled nurses practice. This deficit was highlighted in the Harvard School of Public Health study and a recommendation from this study and it recommended that attention be given to developing measures of positive clinical outcomes (Needleman, Buerhaus, Mattke, Stewart and Zelevinsky, p 142).

For further information on other recent research in this important area please see the relevant papers produced as part of the current *National Review of Nursing Education*. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled *Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes*

The levels of adverse events in Australian health care settings are a source of serious concern to the QNU. Many of these events can be attributed to “systems failures” rather than the failure of individual health practitioners. Various strategies that aim to decrease the incidence of adverse events in this country are in the process of being implemented. Of particular interest here are the activities of the *Australian Council for Safety and Quality in Health Care*, a body established under the auspices of the Australian Health Ministers Forum. Although there is reluctance on the part of some health professionals to be involved in the activities of the Council, the QNU and other nursing organisations welcomes this long overdue initiative. We believe that it is critically important that nurses are actively involved in driving the Council’s agenda at the health facility level. After all, nurses act as patient advocates on behalf of individual patients every day of their working life. Involvement in the agenda of the *Australian Council for Quality and Safety in Health Care* is for us a logical extension of this advocacy role to a systemic/collective level. Nursing must therefore be an integral part of the agenda to improve health outcomes for the whole community.

The QNU also wishes to make brief comment on some of the assertions contained in the discussion paper. An assertion is contained in the first paragraph that “restrictions on who can practice nursing or midwifery may lead to increased prices for nursing services and a reduction in choice of service providers available to consumers”? Where is the evidence to support this very strong assertion? It certainly isn’t contained in the discussion document, rather the ideology of competition has merely been blindly accepted.

On another point, an assertion is made that shortages of qualified nurses may lead to increased prices, but there is no evidence that regulation has contributed to this. The current nursing shortages have not resulted from regulation and have not been “manufactured” by the profession. The reasons for these shortages are complex, but in our view are in large part can be attributed to the systemic and longstanding undervaluing of nurses and nursing. A fundamental logical inconsistency is apparent to the QNU relating to the issue of “market forces”. Market forces are accepted when they drive prices down, but railed against when prices are driven up. We watch with interest what determination the ACCC will make with respect to an application by the Victorian government (Health Purchasing Victoria) for exemption from prosecution under the *Trade Practices Act* with respect to their plan to limit payment to agency nurses employed in public hospitals in Melbourne and Geelong.

With regards to assertions contained in the second paragraph in this section, there are a number of issues that need to be addressed. Firstly, the use of the word “restrictions” in the first sentence is overly narrow. There are significant reasons for maintaining “regulation” of nursing – regulation goes beyond restrictions on practices and encompasses issues such as standards for nursing education. Secondly, the over-emphasis on “treatment” in the second part of this paragraph is also of concern. Assessment, planning, implementation and evaluation (ie the nursing process) is a broader concept that goes beyond the narrow confines of treatment. (This demonstrates a fundamental misunderstanding of the nursing process - eg also relates to the promotion of health and well being.)

The table on page 12 that summarises the “main health risks” for consumers is woefully inadequate and understates the potential magnitude of risks associated with lack of regulation or inadequate regulation. That is it could result in death or serious injury.

The way in which the problem “information asymmetry” is presented on page 12 is of particular concern. The definition in the footnotes, though brief, is correct. The conclusions that are drawn about information asymmetry in the body of the text are misleading and have missed the point about information asymmetry. Regulation of the professions exists because of information asymmetry. The codification of expectations about standards and scope of nursing practice, necessary educational qualifications and ethical standards are required to protect the consumer. Many consumers will never be able to objectively assess the relevant standards of practice of nurses, midwives and other professionals. Regulation of the professions gives the public confidence that there are minimum standards that must be met to practice. Governments intervene to regulate professions for this purpose. If it can be demonstrated that the regulatory framework is not meeting its objectives (and it has not been in this instance – not in the paper at least) then that is an issue that requires

urgent attention via the strengthening of regulatory provisions. It has not been demonstrated how “the lack of information may create incentives to decrease the quality of nursing services”. Such a serious assertion must be challenged and demand explanation and further examination. Indeed, the provision of information to and advocacy for patients is central to the role of the nurse. The issue of information asymmetry is critically important and needs to be addressed, but it will not be addressed by the application of competition in health care. It must be addressed via maximising consumer education of health services, treatment options and rights. But no matter how much information of this nature is provided knowledge imbalance will still exist. This could relate to matters such as diagnosis (including differential diagnosis), disease aetiology and progression, treatment options and prognosis. Such information is inherent in the attainment of specialised knowledge. Even health professionals in one specialty area will experience information asymmetry in comparison to colleagues in another specialist field. This is the nature of professional knowledge.

It is disappointing that this section of the discussion document on NCP review of *Nursing Act 1992* did not make mention of international work by Styles and Affara on a framework for regulation of nursing. This framework was proposed in their 1997 work on behalf of the International Council of Nurses titled *ICN on Regulation Towards 21<sup>st</sup> Century Model* (page 17). This highlights the need for a nationally (and indeed internationally) consistent approach to nurse regulation and provides a 12-point schema for the assessment of the adequacy of current regulatory regimes.

These 12 principles are:

1. purposefulness
2. relevance
3. definition
4. professional ultimacy
5. multiple interests and responsibilities
6. representational balance
7. optimacy
8. flexibility
9. efficiency and congruence
10. universality
11. fairness and
12. inter-professional equality and compatibility

Although this framework represents the “ideal” and may also be seen as not being appropriate in all settings (eg may not be appropriate in all cultures), it provides an interesting debating point and potentially an aspirational framework for nursing regulation.

The *National Review of Nursing Education* has prepared a detailed research paper on the regulation of nurses in Australia that may be of interest to this review.

### **3.3 Background to, and administration of, the Anti-competitive provisions**

#### **3.3.1 Scope of Nursing Practice**

With regards to this section, we wish to have it noted that the list of nurses roles on page 13 that is provided from the NHMRC 1991 document, is in our view it is woefully out of date. There has been significant advancement in the scope of nursing practice in the last decade. For example, the roles of advanced practice nurses such as Nurse Practitioners are developing. More recent views on this topic can be found in the research documents arising from the current *National Review of Nursing Education*.

We particularly wish to comment on the paragraph beneath the dot points in this section that refers to difficulty experienced in defining the scope of nursing practice. The quote from the UK regarding nurses struggling to define its character is a misleading and unsubstantiated assertion. When you go to the actual article that is quoted (in *Nursing Times*) you find that the statement quoted in the discussion paper is the lead sentence of the article, but this assertion is sourced to another 1996 article in the *British Medical Journal*. This begs the question, who is confused about the emerging role of nurses, doctors or nurses. We reject the assertion that there is confusion of roles amongst nurses – the situation is evolving but decisions about the advancing scope of practice are rooted in attaining the necessary knowledge and skills before the scope of practice is advanced.

The comment in this section paper on the non-prescriptive approach of the QNC to scope of practice issues must be seen in the context of the powers of the QNC being conferred through legislation and that the QNC is ultimately accountable to parliament through the Minister for Health. Can it be demonstrated that these accountability mechanisms are wanting?

The discussion paper makes an unsubstantiated assertion that nurses are now undertaking roles that were previously the domain of other health professionals. In our view this demonstrates a limited knowledge of the history and development of nursing and requires substantiation.

On the general issue of the regulation of the scope of nursing practice, we wish to place on the record our strong and long held view that those currently unregulated care providers that are undertaking nursing practice must in some way be regulated by the QNC. This includes AINs (howsoever termed) and ATSI health workers. If these health workers are not regulated this will, in our view, merely aid the substitution/de-regulation agenda that is currently gaining ascendancy. This is a critically important

issue, as such regulation would better ensure standards of patient or resident care. Just because someone is a client in an aged care facility or a remote indigenous community should never mean that they are not entitled to accountability for the standard of health care that is being provided to them.

The Australian Health Minister’s Advisory Committee (AHMAC) is currently investigating the appropriateness of establishing registration for ATSI health workers, a move that is welcomed by the QNU. (Cultural appropriateness is an important issue that must be addressed in the delivery of health services in indigenous communities but this must be balanced with the rights of these communities to expect the same level of regulation as non-indigenous clients. The same is true for the argument about aged care being de-institutionalised and made “home like”. These arguments can merely mask a deregulation/substitution agenda, which enable employers to utilise unregulated and hence less costly care providers.)

With respect to the matter of the supervision of ATSI health workers, we wonder what is the QNC’s view of the assertion on p 17 that most (though not all) ATSI health workers report to a registered nurse.

We also refer to the section on QNC prosecutions since 1996 - This section has failed to address the issue of statistics on the number of investigations by the QNC on practice issue complaints. This is a critically important component of regulation by the QNC. The QNC does not merely deal with those who “hold themselves out to be nurses” or have failed to maintain registration. Another critical component on regulation is ensuring the maintenance of acceptable standards of nursing practice. It is important to also assess the statistics from the QNC regarding investigation of complaints relating to professional conduct. The following tables represent a breakdown of the types and source of complaints made since 1996: (Source *QNC Annual Report 2001*.)

#### **Types of Complaints to QNC 1996 –2001**

<b>Type of Complaint</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Incompetence	1	7	2	9	4	22
Bad Health & Conduct	3	7	4	5	5	6
Conduct	8	28	29	29	36	44
Health Concern	8	18	30	19	54	43
Boundary Violation	7	3	1	2	5	3
Whole Agency			3			7
Other	20	5	10	1	8	10
<b>TOTAL</b>	<b>47</b>	<b>68</b>	<b>79</b>	<b>70</b>	<b>112</b>	<b>135</b>

#### **Source of Complaints**

<b>Source</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Consumer	3	12	10	4	5	11
Chief Health Officer/Environmental Health	5	1	2	1	5	1

Director of Nursing	20	26	26	31	48	57
Employer/District Manager	3	5	9	11	25	23
Health Rights Commissioner	6	4	4	4	3	5
Other Health Professional	1	2	2	3	3	10
Other Including newspaper	5	9	20	12	16	20
Peer/Nurse	4	9	6	4	7	8
<b>Total</b>	<b>47</b>	<b>68</b>	<b>79</b>	<b>70</b>	<b>112</b>	<b>136</b>

The assessment of nurse educational standards and course curriculum and the setting of policies and guidelines must also be considered as an essential part of the regulatory function of the QNC. The review of the number of prosecutions and who is “targeted” in these processes is of course an important part of the review of how the QNC has utilised its regulatory powers. But to look at the number of prosecutions alone, in the absence of the other regulatory functions of the QNC paints a very narrow picture of the broad regulatory role and function of the Council. We would strongly urge that a broader assessment of the regulation by the QNC be undertaken as part of this review as this gives a better understanding of the nature and extent of consumer protection inherent in the Council’s processes.

The assertion contained in the first paragraph on page 18 that the current wording of the act makes it difficult for the public to adequately understand what constitutes nursing practice applies equally to all professions. The scope of practice of all professions is inherently difficult to describe to the public because this is based on a body of expert knowledge that is not possible to be contained in legislation. This is why peer management is central to the operation of professions.

With respect to the assertion that “until recently” the QNC has chosen not to prosecute unqualified workers, two questions have not been asked. Firstly, how many unqualified workers have been prosecuted recently and secondly have such prosecutions only commenced recently?

The paper appears to be implying that QNC’s approach to date appears to have concentrated on the pursuit of the alleged misconduct of individual practitioners rather than addressing more complex systemic issues. Although we acknowledge that a critically component of the QNC’s role includes ensuring the safe practice of individual nurses, we would say that this occurs in a context and this context is not always acknowledged.

### **3.3.2 The Scope of Midwifery Practice**

We wish to again highlight to this review that some useful materials regarding the scope of midwifery practice can be found in the research papers produced as part of the current *National Review of Nursing Education*.

### **3.4 Approaches in other jurisdictions**

For further analysis on the approach to regulation in other jurisdictions please see the relevant papers produced as part of the current *National Review of Nursing Education*. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled *Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes*

## **4.0 Options**

### **4.1 Options for Nursing**

#### **4.1.1 Option 1 - Title Only**

Not supported.

#### **4.1.2 Option 2 - Title and Core Practice Restriction**

Not supported.

#### **4.1.3 Option 3 – Title and Broad Practice Restriction**

##### **Option 3 A**

Not preferred – needs to be extended. (See Option 3 C below.)

##### **Option 3B**

Not preferred – needs to be extended. (See Option 3 C below.)

##### **Option 3 C – Title and Broad Practice Restriction**

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must contain the necessary exemptions for other regulated health professionals and those with “Nursing” in their position title (eg Assistants in Nursing and Nursing Students) who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council’s powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

## **4.2 Options for Midwives**

### **4.2.1 Option A – Title Only**

Not supported.

### **4.2.2 Option B Title and Core Practice Restriction**

Not preferred. A Title and Core Practice Restriction is Supported, but with the core practices that are restricted must be expanded. See Option C below.

### **Option C Title and (Broader) Core Practice Restriction**

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes “core” midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

### **Specific Questions to Be Answered as Outlined in 4.0 Options (p 23) Which are your preferred options for nursing and midwifery?**

**Nursing:** Our preferred option is new option 3c as outlined above as:

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must

contain the necessary exemptions for other regulated health professionals and those with “Nursing” in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council’s powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

**Midwifery:** – Our preferred option for midwifery is a new C option, a title and (broader) core practice restriction as outline above as:

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes “core” midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

### **What are the reasons for your preferred options?**

**Nursing** -In our view title restriction alone is insufficient to protect the community as it fails to regulate actual nursing practice –ie it ignores those who are undertaking nursing practice under another title. There is a need to regulate unqualified practitioners who are undertaking nursing practice given that the overriding rationale for act is consumer protection. Currently there is a substitution/de-regulation agenda in some areas (eg aged care) that is facilitated by deficiencies in the act and/or limited action by QNC against employers engaged in such activities.

We accept there is a need for better mechanisms that would facilitate the definition of nursing practice, but believe that it would be too complex and restrictive to construe a definition of nursing practice for legislative purposes.

A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

**Midwifery** – We need a broader definition of midwifery practice because there are risks to the consumer at all stages of the confinement not just at the time of Labour. The title of midwife needs to be protected to ensure that persons who are not appropriately qualified do not engage in practices that may endanger a mother or foetus/infant. A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

**Which options do you consider workable or feasible?**

The preferred options stated above are the only ones that we believe are workable and feasible.

**What costs and benefits are there for each option, in relation to your activities/operations and that of other stakeholders?**

We have attempted to quantify the costs and benefits associated with each of the options but have found that this is impossible to do in a meaningful way. We can talk broadly about the issues that need to be considered, but when it comes down to quantifying actual costs and benefits of each option, we question the validity of such an analysis. For example, it is difficult enough identifying opportunity costs associated with each option let alone attempting to determine the full range of possible costs and benefits.

The advantages and disadvantages contained in the discussion paper are acknowledged as being worthy of consideration.

**Where possible, can you estimate the monetary value of the cost or benefit?**

Quantification of costs in dollar terms is extremely difficult given the complexity of the health sector. The main costs would relate to decreased quality of care and hence patient outcomes (eg increase in adverse events, increased length of stay etc) and also increased litigation. Indeed we believe that it is very dangerous and indeed inappropriate to attempt to quantify costs in dollar terms in the absence of a rigorous and agreed methodology for quantifying costs.

**Which options, for both nursing and midwifery, do you consider best meets the objectives of the legislation?**

The options that we have stated are preferred – see above

**In relation to the options for nursing:**

**(a) should the title “nurse” , and derivatives such as assistant in nursing, be restricted to persons authorised under the Act; and**

Yes, we have made submissions to this effect for some time now. This is currently a serious deficiency in the Act. Any person, howsoever termed, undertaking nursing practice needs to be regulated.

**(b) which other titles, if any, should be restricted to only persons authorised under the Act?**

We currently can not identify any other titles that need to be authorised under the act so long as better mechanisms are available to facilitate the determination of whether someone is undertaking nursing practice. (Once determinations are made then these could, for example, be made publicly available on the Internet and in other forms to facilitate public awareness of what constitutes nursing practice. Consumer input into such determinations would also be required so as to ensure that consumer expectations are taken into consideration.) This would ensure that those engaged in nursing practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

**In relation to options for midwifery:**

**(a) should the title “midwife” be restricted to persons authorised under the Act; and**

Yes.

**(b) which other titles, if any, should be restricted to only persons authorised under the Act?**

We currently can not identify any other titles that need to be authorised under the Act. So long as the definition of midwifery practice is extended in line with our definition and there are mechanisms are available to facilitate the determination of whether activities constitute midwifery practice then this should be sufficient. This would ensure that those engaged in midwifery practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

**In relation to option 3B for nursing, how should “nursing practice” be defined in the Act?**

This matter is complex and needs further urgent consideration. It may not be possible to establish a clear definition of nursing practice that is suitable for legislative purposes. This is not to say that mechanisms that facilitate such definitions being

made in an appropriate and timely manner can not be given effect under the act. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

**In relation to option B for Midwifery, is the proposed core practice adequate to ensure that only midwives can practice midwifery activities that carry significant risks if performed by unqualified persons?**

As stated above, we believe that the definition of midwifery practice needs to be broader to ensure consumer safety. Our suggestion is as follows:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

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## Summary of QNU Recommendations

Further to the recommendations made in our 2001 submission to this review, the QNU makes the following recommendations:

Recommendation 1: That as part of this review process public input be sought on the threshold issue of the appropriateness of subjecting services such as health (and in this instance nursing) to the application of National Competition Policy.

Recommendation 2: That the Public Benefit Test assessment criteria include those that measure the impact on the Government's Priority Outcomes as well as specific criteria to measure health outcomes.

Recommendation 3: That legislative amendments be made to the *Nursing Act 1992* to require the Queensland Nursing Council to regulate those currently unregulated health care providers who are undertaking nursing practice. (With the proviso that other regulated health providers are exempt from this provision so long as they are working within their profession's scope of practice.)

Recommendation 4: That mechanisms that facilitate the definition of nursing practice be investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

Recommendation 5: That legislative amendments be made to the *Nursing Act 1992* that protect the use of title of nurse and midwife. Further to this, that a title exemption also be given to those with the word "Nursing" in their title (eg Assistant in Nursing" or "Nursing Student") who are working under the direct and indirect supervision of a Registered Nurse.

Recommendation 6: That the current restrictions relating to the provision of a nursing service and nursing practice contained in the *Nursing Act 1992* be retained. (Note: Option 3b does not include the nursing service component.)

Recommendation 7: That the current legislative provisions of the *Nursing Act 1992* be strengthened to enable the Queensland Nursing Council to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

Recommendation 8: That a Title and Broad Practice restriction be adopted (a combination of Options 3A and 3B) that: maintains the current nursing service and practice restrictions. This option (3 C) must contain the necessary exemptions for other regulated health professionals and those with "Nursing" in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained.

Recommendation 9: That the *Nursing Act 1992* be amended to include the following definition of midwifery practice:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (f) *Education and Research.*

Recommendation 10: That a Title and Core Practice restriction be adopted for Midwifery and that the definition of the Core Practice include activities outlined in recommendation 9 above.

## 1. Introduction/Review Background

### 1.1 Purpose of the Review

In our previous submission to this review of the *Nursing Act 1992* the Queensland Nurses' Union (QNU) outlined our general serious concerns about the appropriateness of applying National Competition Policy (NCP) principles in the health sector. We wish to reiterate some particularly important aspects of these concerns again and also delve more deeply into the notion of the application of competitive market principles in health generally and in particular to the practice of nursing.

Firstly, the QNU rejects the assumption inherent in the competitive model – namely that competition in itself is always a worthwhile objective in its own right. In this model competition is an unquestioned virtue, one that assumes paramount importance in its own right. The QNU is particularly concerned that the implementation of NCP has been driven by economic imperatives at the expense of social welfare considerations and the notion that competition will in itself lead to increased efficiency. The assumption appears to be that both competition and efficiency are always intrinsically beneficial and socially desirable objectives. The flaws of these assumptions are apparent in a number of sectors where NCP has been applied.

The application of the competitive model in a sector such as health must be done with extreme caution and on a case by case basis given that it is *“in the health sector where we almost certainly encounter the most complex market conditions in the economy.”* (Watts J, 1.15) The problems of applying a narrow competitive model in health have received considerable attention in the discipline of Health Economics.

There are difficulties associated with applying competitive models to health generally. We will highlight some of these difficulties. It is then important to highlight how nursing differs from other health professions, and in the process expose that these issues have not been given appropriate attention to date in the debate around the application of competitive principles to nursing.

In theory perfectly competitive markets are based on four assumptions that: there are many independent firms and consumers in the market, all firms are producing identical products, firms can enter and exit the market freely and both firms and consumers have “perfect information”. (Pindyck and Rubinfeld, p 283-284) In reality perfectly competitive markets rarely, if ever, exist. It is obvious that “market” in health fails to meet this model in many ways. This is due to factors that are intrinsic to health. For example, in health care markets “perfect information” is particularly problematic, as “information asymmetry” is inherent in the transactions that occur between providers and consumers (as indeed it is in the provision of professional services generally).

Sources of “market failure” in health are many and varied and require government intervention in health markets. The sources of market failure that are intrinsic to health are summarised by Watts (p2.4-2.6). She highlights that these relate to issues such as externalities, the need for the provision of public goods (and hence why

public monopolies in such instances may be more efficient), quality assurance and the need for protection of the community, the complexity of the relationship between health and the consumption of health services, the provider as agent, moral hazard and supplier induced demand and adverse selection. It is not appropriate or necessary to explore all these issues in detail now. It is suffice to say that the health market is significantly different to other markets and it has its own inherent complexities. This in not an argument for not examining the health system, rather we question the appropriateness of applying such a theoretical model in an uncritical manner.

There are many sound reasons why it is not appropriate to apply competitive principles in an industry such as health. The QNU believes that maximising outcomes (and efficiency) in the health “industry” is largely predicated on cooperation between all players, not competition. Most importantly in our view are the moral or ethical components to “transactions” in health. Because of this it is not possible to reduce transactions in health to the status of transactions that occur in the marketplace. Instead what may require analysis is not whether the health system, the legislation that governs it (including regulation of the professions) and the practices in the health system “survive” an analysis under NCP principles but rather whether it stands up to ethical analysis. Maybe more tools are required that facilitate ethical analysis, not economic analysis. An examination of one important feature of health, the nature of information asymmetry highlights these inadequacies.

Information asymmetry results in the provider of health services acting as the agent for the consumer. The complexity of and difficulties associated with this agency relationship are often not acknowledged, especially when it is the case that the agent has a vested interest in the advice/service being given. This is especially the case where a fee for service arrangement exists. Such arrangements are not an established feature in nursing. Indeed this is a significant issue that needs to be highlighted as part of this review.

Nursing differs from other regulated health workers such as many doctors and dentists and some allied health professionals where a fee for service arrangement exists and the profession sets the fee schedule. Very few, if any nurses operate under a “fee for service” arrangement. (It is also important to remember that not all doctors, dentists and allied health professionals operate under such arrangements.) Remuneration arrangements for nurses are established under the auspices of independent industrial relations tribunals. Direct employment by a government department or health agency is the normal employment arrangement for nurses. This is also the case for the emerging Nurse Practitioner role in Australia.

Some may argue that the absence of a “fee for service” arrangement means that nursing does not meet the strict definition of a profession. We wholeheartedly reject this assertion. Nursing in Queensland is self –regulated through the Queensland Nursing Council, is based on a significant body of technical expertise and is governed by a code of conduct. To us, fee for service arrangements that characterise some other health professions are not inherent to the nature of professions. They are indeed a potential source of conflict for ethical professional practice given the nature of transactions that occur between provider and consumer, particularly given the information asymmetry (and hence power imbalance) that exists. Such arrangements may have developed over time to become a feature of some professions. It is even

possible to argue that such fee for service arrangements are encouraged by or are in part a result of the power imbalance (information asymmetry) that exists between the provider and consumer. In summary, remuneration and associated issues (such as the control of the supply of professionals in order to affect the supply of such services) may result from an abuse of “market power” (and institutionalised power) but are not inherent features of professions.

We are labouring this point because we believe that this is an important issue and one that has not received enough attention to date. Nursing differs from other professions that may have abused their market and other forms of power in the past. Nurses do not set their own fees, we do not place onerous limitations on entry into specialty areas (indeed we are currently doing all within our power at present to ensure that the critical shortages that exist in nursing specialties are addressed as a matter of urgency) and we can not be accused of supplier-induced demand. We believe that we can justify the regulation of nursing in the name of public interest – such protection is required to protect not only the sick but the health of the community in general. In our view the benefits of such regulation far outweigh the costs. We also believe that the objective of the *Nursing Act 1992*, “to make provision for ensuring safe and competent nursing practice”, can only be achieved by “restricting competition”. That is, the safety of the community can only be assured by regulating nursing practice and those who can undertake it.

Our fear is that the assumption is that nursing operates in the same way in which other professions that indulge in so-called “anti-competitive” (some may prefer to use the term “unethical”) behaviour. This demonstrates a fundamental lack of understanding of the health system and the manner in which the professions who work in that system operate. In our view this review and in the general debate on the application of NCP to health, the complexities of the health context and power imbalances (not only between consumers and providers but also between the various providers in the system) have not been adequately acknowledged.

The Australian Competition and Consumer Commission (ACCC) has made no secret of the fact that they are paying particular attention to “anti-competitive” behaviour on behalf of the professions. There has been considerable media attention given to the ACCC’s view on actions of some professions in health, most notably medical specialists. We contacted the ACCC in the course of formulating this submission and asked whether they had shown any particular interest in the regulation of the nursing profession and whether they had an understanding that nurses do not operate under a “fee for service” arrangement nor is the profession involved in setting their fee schedule. We were advised that little, if any consideration has been given to nursing to date. Given that nurses make up the largest single professional group in health we find this quite astounding. We are concerned that this indicates a fundamental lack of understanding of the way in which the various professions operate within the health sector. We are also concerned that a rather uncompromising approach may be taken to all health professions. Has the ACCC clearly identified the types of behaviours that they consider “anti-competitive”, who is involved in this, quantified the impact of this behaviour and then examined all possible avenues for remedy?

In a recent speech to the Centre for Health Program Evaluation at Monash University, Professor Allan Fels outlined the ACCC’s concerns about how the professions are

affecting the efficient delivery of health care in this country. In this speech he highlighted some valid and longstanding issues of concern that need to be publicly examined and debated. Near the end of his address (Fels, p 20) he made an important contextual differentiation:

*“I believe that professionals, including doctors, and lawyers, and dentists, should be treated no differently to others engaged in supplying services and goods to the public and who choose to operate as businesses.”* (emphasis added)

If regulatory frameworks exist that are acceptable to both the community and the professions and ensure ethical behaviour (even when a professional chooses to operate as a business) then would it be necessary to apply an economic framework to address behaviours that negatively impact on the common good? Is it the case that the actions of a few may have called the actions of all into question? What are the implications for those professionals who do not act as businesses? The application of theoretical economic dogma will not address these issues that essentially relate to power imbalances and ethical behaviour. Central to addressing these concerns is access to meaningful information by consumers that enable informed choice and mechanisms to address, as far as is possible, power imbalances in health. This is a significant agenda. The NCP review processes of the professions may highlight issues of concern but we believe that the remedies required are the responsibility of government, as elected representatives of the community, not the market.

Governments determine that such regulations are necessary in the interest of public safety. Some argue that regulation of this nature provide unnecessary barriers to competition. The alternative view is that such minimum regulations are required to be set by government because the market, left to its own devices, will not ensure the public good. There are costs to both government and private health care providers associated with the administration of such regulatory frameworks but there are also obvious benefits as well. Government, on behalf of the community as a whole, conducts analyses of the costs and benefits of such regimes and legislates and administers accordingly.

We are pleased to see that the current government has moved away from an unquestioning approach to the NCP. The Queensland Treasury document titled *Public Benefit Test Guidelines: Approach to undertaking Public Benefit Test Assessment for Legislation Reviews under National Competition Policy* details the change in the government’s approach to such reviews. This document details (at p 6-7) the undertakings given under the Competition Principles Agreement (CPA) that:

“ ... legislation should not restrict competition unless it can be demonstrated that:

- *The benefits to the restriction to the community as a whole outweigh the costs;*
- and*
- *The objectives of the legislation can only be achieved by restricting competition*

*This means that NCP reviews must not only consider whether an existing/proposed restriction provides a public benefit, but also whether other options would achieve a greater public benefit.”*

The last sentence of this quote highlights an important point that is relevant to the current review of the *Nursing Act 1992*. The November 2001 Discussion Paper highlights some examples of potential inadequacies of the current regulation of nursing practice in Queensland. A number of issues highlighted in the discussion paper are also of concern to the QNU, and were highlighted in our previous submission to this process. The first relates to the need for the Queensland Nursing Council to regulate those people who are currently not regulated by the council and yet are carrying out nursing practice (at times without the supervision of registered nurses). The second issue highlighted in the discussion paper is the need for a clear and concise definition of “nursing practice”(that is suitable for legislative purposes). This second issue is perhaps more difficult to address than the first. However, in our view attempts should be made to improve the current legislation so as to strengthen the benefits to the community. Although this may not be possible through a legislative definition other avenues to address this issue need to be investigated as a matter of urgency. (Our interpretation of “other options” includes the strengthening or clarification of current provisions, not the replacement of regulation with other forms so called “regulatory alternatives”.)

Another important point made in this Treasury document is found in a following paragraph (p 7):

*“The need to carry out the review of legislation recognises that government regulation can sometimes create unwarranted barriers to entry or other restrictions on business which limit consumer choice, stifle innovation and reduce incentives for achieving better efficiency. **However, the review of legislation does not imply a need to introduce or ensure competition for its own sake nor imply that competition objectives should take precedence over other important public policy objectives.**”*  
(our emphasis)

This is a critically important shift in policy approach by the Beattie government that is welcomed by the QNU. A fundamental criticism that the QNU has of past application of NCP has been that too often competition for competition’s sake has been an overriding objective, at the expense of other equally (or more) important objectives such as equity, access and effectiveness. Under the nationally consistent approach to the annual reports on government service provision includes the need for the development of indicators to measure such outcomes. (See *Report on Government Service Provision 2001*.) However, to date undue emphasis has been placed on the development of indicators to measure efficiency. A number of efficiency (unit cost) indicators have been developed for public hospitals, (eg Recurrent cost per casemix adjusted separations, Labour costs per Casemix adjusted separations, User cost of capital per Case mix adjusted separation, Casemix adjusted relative length of stay and under development is the indicator Cost per non-admitted occasions of service). However, work on developing effectiveness indicators (covering areas such as quality, appropriateness and accessibility and access) has for too long been wanting. In our view indicators of outcomes that are not related to efficiency outcomes in health are an integral part of the PBT assessment of legislative reviews affecting the health sector. Until such time that these are developed it would be inappropriate to base decisions on whether legislative changes are warranted until such time that these are developed.

Further to this, the Queensland Treasury document states (p 8) “*that the combined effects of the costs and benefits to the community must be assessed against the Government’s Priority Outcomes.*” These are:

- “ *More jobs for Queenslanders*
- Building Queensland’s regions*
- Skilling Queensland*
- Safer and more supportive communities*
- Better quality of life*
- Valuing the environment*
- Strong government leadership”* (p 8)

We believe that assessments of the impact of the application of NCP principles to nursing regulation has an impact in most of these priority outcome areas, therefore making this review all the more complex. Will the final Public Benefit Test document assess against all of the above criteria, and if so why haven’t those making submissions to this review been requested to make comment on these to assist the formulation of the PBT report?

It is also important to remember that there is a broader context to consider. All of the issues of concern that we have raised in this section highlight the complexity of applying a competitive model used in the “trade of goods” to the “trade of services”. This debate is of international significance given the undertakings given to date by the Australian government to international bodies such as the World Trade Organisation (WTO) in the current round of General Agreement on Trade in Service (GATS) negotiations.

Finally, as part of this review process it is essential to revisit the original objectives of the *Nursing Act 1992*. These must be kept at the forefront of this review process. The objective of the act is: “*to make provision for ensuring safe and competent nursing practice*”. Further exploration of this issue can be found in the second reading speech of the Bill by the then Minister for Health, Hon Ken Hayward. This stated in part:

*“Although it is true that regulation of a profession is a benefit to the members of that profession – a benefit which accrues by virtue of status afforded through Government recognition, and in being able to self-regulate – the main purpose of such regulatory activity is of increasing importance today to both the public and the Government. That purpose is if course, consumer protection. Hence the objective of the Bill explicitly refers to “ensuring safe and competent nursing practice. I believe that the role of regulatory bodies such as the Queensland Nursing Council, will expand, particularly with the Health Rights Commission becoming operational from 1 July 1992, so as to eventually provide a fully integrated consumer protection system in Queensland.” (Hansard, 5 November 1992, p 78)*

He concluded this speech by stating:

*“This Bill is a progressive piece of legislation. It is one which makes provision for the many changes that are occurring in nursing, and it does this in such a way that I see certain features of it acting as the model for review of legislation governing other professional registration boards under my portfolio. I commend the Bill to the honourable members of this House.”* (Hansard, 5 November 1992, p 80)

From these Hansard extracts it is apparent that the overriding concern of the government at the time was consumer protection. This must remain the overriding concern of the government of today during this review process. It is also apparent to the QNU that the Health Minister at that time saw this legislation as a “model” for legislation governing other health practitioners. At the same time he envisaged the strengthening of consumer protection through other related reforms (eg through its relationship with legislation governing the Health Rights Commission). Whether this strengthening of consumer protection has indeed occurred since 1992 must be considered as part of this review, as should how effective other related bodies such as the Health Rights Commission have been at achieving this critically important objective.

## **1.2 Review Process**

Although we acknowledge and welcome the shift in the state government’s approach to NCP, we do however remain concerned about a number of critical issues. These include the threshold issue of “onus of proof” that underpins NCP, how reviews are conducted and the adequacy of tools available to quantify costs and benefits.

A basic tenet of NCP is that competition is beneficial and only in instances where it can be clearly demonstrated that competition is “not in the public interest”, are exemptions to be granted. In our opinion, particularly in the area of the provision of essential services by government, the opposite should apply. NCP should only be implemented in areas where it can be clearly demonstrated that competition is in the public interest, that is, “onus of proof” should be reversed. This concern has in part been addressed by the Beattie government’s new approach to NCP reviews. The issue of how reviews are conducted is still of concern.

The QNU believe that government must always conduct NCP reviews. They are so important that the government must have confidence in and remain totally accountable for all such reviews. We are pleased that the review of the *Nursing Act 1992* has remained “in-house”, however the same can not be said of the review of legislation that covers other health professionals. The consultancy firm Price Waterhouse Coopers is conducting this review. We have written to both the Premier and Queensland Health to express our concern about this issue as well as our concern about consistency of approach in reviews. The Premier has responded to our concerns regarding review processes, providing us with a copy of Queensland Treasury’s Public Benefit Test Guidelines. The fundamental principle relating to the appropriateness of transference of responsibility for conducting reviews to corporations has however not been addressed to our satisfaction. We stress again that is our view that government, the elected representatives of the community, must be

responsible for the total carriage of all such reviews. How it is determined whether reviews should be considered “minor” or “major” reviews is also of concern. The review of the *Nursing Act 1992* is considered a minor review but it is debateable whether this should be considered a major review (and therefore be the subject of more robust PBT assessment) given the significant potential for adverse health effects should barriers to practice nursing be weakened or removed. The determining factor appears in part to the availability and adequacy of tools to quantify the impact of change.

This brings us to our final issue of concern, whether sufficient robust tools currently exist to accurately estimate the economic and social impacts of any proposed regulatory change. Quite often such impacts are impossible to accurately quantify. This is particularly the case when assessing such impacts in a complex area such as health. We believe that when there is any doubt then the government must err on the side of caution and determine not to de-regulate. Econometric models alone can not predict all costs and benefits in a PBT assessment. The effect of the de-regulation of health professions on health outcomes and quality of care for the community is difficult to fully quantify. Such analysis has only fairly recently begun to occur in some areas. For example, an increasing body of US research is demonstrating “*that increasing levels of qualified nursing staff impact positively on broad indicators such as length of stay and mortality rates, as well as adverse events such as nosocomial infections.*” (Chiarella and Crisp, p 6)

We have a number of other concerns that we wish to highlight about the review process to date. Firstly, we are concerned that only 27 submissions were made to the initial call for comment advertised in March 2000. We believe that this is an inadequate response and remain particularly concerned that the views of consumers may not have been adequately obtained to date. This second call for submissions is therefore very welcome. With respect to this though, we are concerned about the timing of this second part of the process, given that further submissions were called for at the end of November 2001 and are due by 28 January 2002. We are concerned that the intervening Christmas period will result in a decreased response rate. The QNU, for example, has not been able to adequately consult with our membership due to the timeframe for comment. Other bodies and individuals (eg nurse academics) may also not be provided with adequate time for consideration of these issues given that many institutions “close down” for protracted periods over the Christmas break.

Another issue of concern is that the QNU and other organisations/bodies that represent the collective interests of nurses are not specifically mentioned in the list of key stakeholders contained on pages 5-6 of the discussion document. Individual clients, nurses and midwives, nursing support workers, the QNC, organisations that provide health services and employers are all mentioned but not the QNU (or other nursing organisations). This may be merely an oversight, but even so is of significance. As a representative of over 28,600 nurses in Queensland, the QNU is a significant stakeholder in this process. Given that NCP has been widely interpreted as being part of a wider ideological agenda that promotes the primacy of the marketplace and individual players in it at the expense of collective or social goals, this is a worrying oversight that may only serve to reinforce this perception.

For further explanation of our overriding issues of concern about the ideology underpinning NCP and its application to the health sector generally and nursing specifically also refer to section 1.1 above and our previous submission to this process.

## **2.0 Industry Profile of Nursing and Midwifery**

### **2.1 Industry Profile of Nursing**

#### **2.1.1 The Role of Nurses**

The International Council of Nurses defines a nurse in its constitution as “a person who has completed a program of basic nursing education and is qualified/authorised in his/her country to practice nursing” (ICN Constitution 1999, Article 6). The Australian Nursing Council Incorporated (ANCI) has published national competency standards for registered and enrolled nurses (ANCI, 1990 and 2000).

The ANCI defines the registered nurse as a first level nurse educated in degree level courses in universities. Registered nurses are licensed to practice nursing in a wide variety of health care settings and are registered to practice without supervision, assume accountability and responsibility for all their actions and aspects of care.

The Enrolled Nurse is defined by ANCI as a second level nurse who provides nursing care within the limits specified by education and the registering authorities’ licence to practice. Enrolled Nurses work under the direction and supervision of registered nurses but retain responsibility for their own actions and remain accountable to the registered nurse for all delegated functions.

In relation to the role of unregulated workers who assist with nursing work, the ICN Position Statement *Assistive or Support Nursing Personnel* states:

*“That the role, preparation, standards, and practice of assistive nursing personnel must be defined, monitored and directed by registered nurses.”*

It is important to stress that since the publication cited in your discussion paper the scope and breath of nursing practice has changed considerably. It is more essential that more recent publications on this issue are reviewed. For example, the ICN Position Statement on the Scope of Nursing Practice states that “Nurses’ spheres of responsibility include giving direct care, supervising others, leading, managing, teaching, undertaking research and developing health policy for health care systems.”

More recently, in 2001, Australia’s first Nurse Practitioner was appointed in New South Wales. Other State and Territory Governments including Queensland are currently considering the implementation of this role in their respective jurisdictions.

Further exploration of this matter can be found in the papers produced as part of the current *National Review of Nursing Education*.

### **2.1.2 Composition of the Nursing Profession**

It is of concern that in this section the unregulated nursing assistants are not recognised as contributing to nursing work. For a current exploration of the issues in this section an appropriate source would be the recently released *National Review of Nursing Education Discussion Paper*.

### **2.1.3 Education of Nurses**

There are a number of concerns to the QNU in this section. Namely:

The narrow definition of nurse education contained in the paper.

That it has been almost a decade since the transfer of nurse education to the tertiary sector and there have been significant developments during this period that are not canvassed.

There is a significant public benefit associated with the transfer of nurse education to the tertiary sector that has not been acknowledged.

The importance of improved patient outcomes associated with the employment of qualified nurses (Chiarella and Crisp research paper) has not been adequately explored.

The evolving nature of educational articulation and recognition of prior learning has not been described.

Again, these issues are canvassed well in the current *National Review of Nursing Education Research Papers*.

## **2.2 Industry Profile of Midwives**

### **2.2.1 The role of Midwives**

Please refer to the QNU's previous submission. It is noted that the discussion paper does not indicate that the views of Queensland midwives were sought during the development of the paper. As the discussion paper suggests, there is currently considerable debate in relation to the regulation and education of midwifery practice.

## **3.0 Current Regulatory Arrangement**

### **3.1 Objective**

See comments in section 1.1 on the overriding objective of the act being consumer protection.

### **3.2 Rationale for the regulation of nursing and midwifery practice**

The main rationale for the regulation of nursing and midwifery practice is the safety of the community. The issue of information asymmetry is intrinsic to health care “transactions”, and this means that government intervention is required to ensure that minimum standards exist for nursing and midwifery education and practice. The QNC is a statutory body set up under legislation and is accountable to the parliament of Queensland via the Minister for Health. That such regulation is required for nursing and midwifery (and indeed the other health professions) is widely accepted. Certainly no arguments to the contrary have been raised in the discussion paper on the NCP review of the *Nursing Act 1992*. Until such time that such arguments are explicitly detailed then we believe that the need for the regulation of nursing and midwifery practice is beyond question.

This is not to say that the current regulatory mechanisms and practices should not be subject to scrutiny. Even though the QNU rejects the ideology underpinning the NCP of nursing, this review process has been useful as it has enabled us to reflect on current practices and has afforded us the opportunity to make recommendations to improve the current regulatory framework. It is also the case that our experience of opposing employers seeking to deregulate areas of health care via the substitution of regulated nursing personnel with currently unregulated care providers highlights current deficiencies in the existing regulating framework. Over recent years we have made a number of submissions to the QNC regarding the need to regulate the “third level” of nurse. Until such time that mechanisms are put in place to facilitate determinations about what constitutes nursing practice then the community will continue to be placed at risk by those service providers who knowingly employ non-nursing personnel to perform nursing tasks. The QNU will make recommendations about potential mechanisms for improving current arrangements in the options section of this paper.

The recent trend towards de-regulation (via substitution of nursing personnel) in health is of particular concern to the QNU. The link between the provision of quality health care and numbers of qualified and regulated nursing personnel is beginning to be clearly identified in overseas research. Research conducted in the USA that was cited in a recent paper by Claire M. Fagin titled “*When care becomes a burden: Diminishing Access to Adequate Nursing*” (p 10) highlights the dangers of a de-regulation agenda in health.

*“Recent studies have shown that close to 20% of hospitalised patients have a serious adverse event during their hospital stay (Silber and Rosenbaum 1997; McGlynn, Naylor, Anderson, et al. 1994). RN- to- bed ratio was the single most important factor influencing hospitals’ differing success rates in saving patients who experienced serious adverse events, according to Jeffrey Silber and his associates.”*

The findings of other recent US research may also be of interest to this inquiry. In June 2001 in Massachusetts a long awaited report of the “*Legislative Special Commission on Nursing and Nursing Practice*” was handed down. The overarching theme of this report was contained in the covering letter to the report by its authors Senator Robert S. Creedon Jr and Brockton Representative Christine E Canavan:

*“Licensed nurses and the patients are inextricably linked. If the working conditions of the licensed nurse improve, direct patient care improves. If patients’*

*concerns for quality care are met, the working conditions for the licensed nurses have been addressed. Their relationship is symbiotic.”*

This inquiry made 6 recommendations relating to improving the working conditions of nurses in that state, including proposing legislation to limit mandatory overtime and establish patient/staff guidelines based on patient acuity levels.

Other recent research from the USA, most notably a report from the Harvard School of Public Health titled *Nurse Staffing and Patient Outcomes in Hospitals*, highlights the important nexus between nurse staffing numbers and health outcomes for patients in some significant areas. To quote from the report (p xxiv) *“In the 11 state all patient analysis, strong and consistent relationships were found between nurse staffing and five patient outcomes, urinary tract infections, pneumonia, length of stay, upper gastro-intestinal bleeding and shock”*. This study also identified strong and consistent evidence of a link between nursing staffing numbers and of “failure to rescue” on major surgical patients. This ground-breaking report recommends developments in data collection systems that would enhance further research in this important area.

It is also important to highlight that the research conducted thus far has tended to concentrate on adverse outcomes if appropriately qualified nursing personnel are not employed, not the positive outcomes that are derived for registered and enrolled nurses practice. This deficit was highlighted in the Harvard School of Public Health study and a recommendation from this study and it recommended that attention be given to developing measures of positive clinical outcomes (Needleman, Buerhaus, Mattke, Stewart and Zelevinsky, p 142).

For further information on other recent research in this important area please see the relevant papers produced as part of the current *National Review of Nursing Education*. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled *Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes*

The levels of adverse events in Australian health care settings are a source of serious concern to the QNU. Many of these events can be attributed to “systems failures” rather than the failure of individual health practitioners. Various strategies that aim to decrease the incidence of adverse events in this country are in the process of being implemented. Of particular interest here are the activities of the *Australian Council for Safety and Quality in Health Care*, a body established under the auspices of the Australian Health Ministers Forum. Although there is reluctance on the part of some health professionals to be involved in the activities of the Council, the QNU and other nursing organisations welcomes this long overdue initiative. We believe that it is critically important that nurses are actively involved in driving the Council’s agenda at the health facility level. After all, nurses act as patient advocates on behalf of individual patients every day of their working life. Involvement in the agenda of the *Australian Council for Quality and Safety in Health Care* is for us a logical extension of this advocacy role to a systemic/collective level. Nursing must therefore be an integral part of the agenda to improve health outcomes for the whole community.

The QNU also wishes to make brief comment on some of the assertions contained in the discussion paper. An assertion is contained in the first paragraph that “restrictions on who can practice nursing or midwifery may lead to increased prices for nursing services and a reduction in choice of service providers available to consumers”? Where is the evidence to support this very strong assertion? It certainly isn’t contained in the discussion document, rather the ideology of competition has merely been blindly accepted.

On another point, an assertion is made that shortages of qualified nurses may lead to increased prices, but there is no evidence that regulation has contributed to this. The current nursing shortages have not resulted from regulation and have not been “manufactured” by the profession. The reasons for these shortages are complex, but in our view are in large part can be attributed to the systemic and longstanding undervaluing of nurses and nursing. A fundamental logical inconsistency is apparent to the QNU relating to the issue of “market forces”. Market forces are accepted when they drive prices down, but railed against when prices are driven up. We watch with interest what determination the ACCC will make with respect to an application by the Victorian government (Health Purchasing Victoria) for exemption from prosecution under the *Trade Practices Act* with respect to their plan to limit payment to agency nurses employed in public hospitals in Melbourne and Geelong.

With regards to assertions contained in the second paragraph in this section, there are a number of issues that need to be addressed. Firstly, the use of the word “restrictions” in the first sentence is overly narrow. There are significant reasons for maintaining “regulation” of nursing – regulation goes beyond restrictions on practices and encompasses issues such as standards for nursing education. Secondly, the over-emphasis on “treatment” in the second part of this paragraph is also of concern. Assessment, planning, implementation and evaluation (ie the nursing process) is a broader concept that goes beyond the narrow confines of treatment. (This demonstrates a fundamental misunderstanding of the nursing process - eg also relates to the promotion of health and well being.)

The table on page 12 that summarises the “main health risks” for consumers is woefully inadequate and understates the potential magnitude of risks associated with lack of regulation or inadequate regulation. That is it could result in death or serious injury.

The way in which the problem “information asymmetry” is presented on page 12 is of particular concern. The definition in the footnotes, though brief, is correct. The conclusions that are drawn about information asymmetry in the body of the text are misleading and have missed the point about information asymmetry. Regulation of the professions exists because of information asymmetry. The codification of expectations about standards and scope of nursing practice, necessary educational qualifications and ethical standards are required to protect the consumer. Many consumers will never be able to objectively assess the relevant standards of practice of nurses, midwives and other professionals. Regulation of the professions gives the public confidence that there are minimum standards that must be met to practice. Governments intervene to regulate professions for this purpose. If it can be demonstrated that the regulatory framework is not meeting its objectives (and it has not been in this instance – not in the paper at least) then that is an issue that requires

urgent attention via the strengthening of regulatory provisions. It has not been demonstrated how “the lack of information may create incentives to decrease the quality of nursing services”. Such a serious assertion must be challenged and demand explanation and further examination. Indeed, the provision of information to and advocacy for patients is central to the role of the nurse. The issue of information asymmetry is critically important and needs to be addressed, but it will not be addressed by the application of competition in health care. It must be addressed via maximising consumer education of health services, treatment options and rights. But no matter how much information of this nature is provided knowledge imbalance will still exist. This could relate to matters such as diagnosis (including differential diagnosis), disease aetiology and progression, treatment options and prognosis. Such information is inherent in the attainment of specialised knowledge. Even health professionals in one specialty area will experience information asymmetry in comparison to colleagues in another specialist field. This is the nature of professional knowledge.

It is disappointing that this section of the discussion document on NCP review of *Nursing Act 1992* did not make mention of international work by Styles and Affara on a framework for regulation of nursing. This framework was proposed in their 1997 work on behalf of the International Council of Nurses titled *ICN on Regulation Towards 21<sup>st</sup> Century Model* (page 17). This highlights the need for a nationally (and indeed internationally) consistent approach to nurse regulation and provides a 12-point schema for the assessment of the adequacy of current regulatory regimes.

These 12 principles are:

1. purposefulness
2. relevance
3. definition
4. professional ultimacy
5. multiple interests and responsibilities
6. representational balance
7. optimacy
8. flexibility
9. efficiency and congruence
10. universality
11. fairness and
12. inter-professional equality and compatibility

Although this framework represents the “ideal” and may also be seen as not being appropriate in all settings (eg may not be appropriate in all cultures), it provides an interesting debating point and potentially an aspirational framework for nursing regulation.

The *National Review of Nursing Education* has prepared a detailed research paper on the regulation of nurses in Australia that may be of interest to this review.

### **3.3 Background to, and administration of, the Anti-competitive provisions**

#### **3.3.1 Scope of Nursing Practice**

With regards to this section, we wish to have it noted that the list of nurses roles on page 13 that is provided from the NHMRC 1991 document, is in our view it is woefully out of date. There has been significant advancement in the scope of nursing practice in the last decade. For example, the roles of advanced practice nurses such as Nurse Practitioners are developing. More recent views on this topic can be found in the research documents arising from the current *National Review of Nursing Education*.

We particularly wish to comment on the paragraph beneath the dot points in this section that refers to difficulty experienced in defining the scope of nursing practice. The quote from the UK regarding nurses struggling to define its character is a misleading and unsubstantiated assertion. When you go to the actual article that is quoted (in *Nursing Times*) you find that the statement quoted in the discussion paper is the lead sentence of the article, but this assertion is sourced to another 1996 article in the *British Medical Journal*. This begs the question, who is confused about the emerging role of nurses, doctors or nurses. We reject the assertion that there is confusion of roles amongst nurses – the situation is evolving but decisions about the advancing scope of practice are rooted in attaining the necessary knowledge and skills before the scope of practice is advanced.

The comment in this section paper on the non-prescriptive approach of the QNC to scope of practice issues must be seen in the context of the powers of the QNC being conferred through legislation and that the QNC is ultimately accountable to parliament through the Minister for Health. Can it be demonstrated that these accountability mechanisms are wanting?

The discussion paper makes an unsubstantiated assertion that nurses are now undertaking roles that were previously the domain of other health professionals. In our view this demonstrates a limited knowledge of the history and development of nursing and requires substantiation.

On the general issue of the regulation of the scope of nursing practice, we wish to place on the record our strong and long held view that those currently unregulated care providers that are undertaking nursing practice must in some way be regulated by the QNC. This includes AINs (howsoever termed) and ATSI health workers. If these health workers are not regulated this will, in our view, merely aid the substitution/de-regulation agenda that is currently gaining ascendancy. This is a critically important

issue, as such regulation would better ensure standards of patient or resident care. Just because someone is a client in an aged care facility or a remote indigenous community should never mean that they are not entitled to accountability for the standard of health care that is being provided to them.

The Australian Health Minister’s Advisory Committee (AHMAC) is currently investigating the appropriateness of establishing registration for ATSI health workers, a move that is welcomed by the QNU. (Cultural appropriateness is an important issue that must be addressed in the delivery of health services in indigenous communities but this must be balanced with the rights of these communities to expect the same level of regulation as non-indigenous clients. The same is true for the argument about aged care being de-institutionalised and made “home like”. These arguments can merely mask a deregulation/substitution agenda, which enable employers to utilise unregulated and hence less costly care providers.)

With respect to the matter of the supervision of ATSI health workers, we wonder what is the QNC’s view of the assertion on p 17 that most (though not all) ATSI health workers report to a registered nurse.

We also refer to the section on QNC prosecutions since 1996 - This section has failed to address the issue of statistics on the number of investigations by the QNC on practice issue complaints. This is a critically important component of regulation by the QNC. The QNC does not merely deal with those who “hold themselves out to be nurses” or have failed to maintain registration. Another critical component on regulation is ensuring the maintenance of acceptable standards of nursing practice. It is important to also assess the statistics from the QNC regarding investigation of complaints relating to professional conduct. The following tables represent a breakdown of the types and source of complaints made since 1996: (Source *QNC Annual Report 2001*.)

#### **Types of Complaints to QNC 1996 –2001**

<b>Type of Complaint</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Incompetence	1	7	2	9	4	22
Bad Health & Conduct	3	7	4	5	5	6
Conduct	8	28	29	29	36	44
Health Concern	8	18	30	19	54	43
Boundary Violation	7	3	1	2	5	3
Whole Agency			3			7
Other	20	5	10	1	8	10
<b>TOTAL</b>	<b>47</b>	<b>68</b>	<b>79</b>	<b>70</b>	<b>112</b>	<b>135</b>

#### **Source of Complaints**

<b>Source</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Consumer	3	12	10	4	5	11
Chief Health Officer/Environmental Health	5	1	2	1	5	1

Director of Nursing	20	26	26	31	48	57
Employer/District Manager	3	5	9	11	25	23
Health Rights Commissioner	6	4	4	4	3	5
Other Health Professional	1	2	2	3	3	10
Other Including newspaper	5	9	20	12	16	20
Peer/Nurse	4	9	6	4	7	8
<b>Total</b>	<b>47</b>	<b>68</b>	<b>79</b>	<b>70</b>	<b>112</b>	<b>136</b>

The assessment of nurse educational standards and course curriculum and the setting of policies and guidelines must also be considered as an essential part of the regulatory function of the QNC. The review of the number of prosecutions and who is “targeted” in these processes is of course an important part of the review of how the QNC has utilised its regulatory powers. But to look at the number of prosecutions alone, in the absence of the other regulatory functions of the QNC paints a very narrow picture of the broad regulatory role and function of the Council. We would strongly urge that a broader assessment of the regulation by the QNC be undertaken as part of this review as this gives a better understanding of the nature and extent of consumer protection inherent in the Council’s processes.

The assertion contained in the first paragraph on page 18 that the current wording of the act makes it difficult for the public to adequately understand what constitutes nursing practice applies equally to all professions. The scope of practice of all professions is inherently difficult to describe to the public because this is based on a body of expert knowledge that is not possible to be contained in legislation. This is why peer management is central to the operation of professions.

With respect to the assertion that “until recently” the QNC has chosen not to prosecute unqualified workers, two questions have not been asked. Firstly, how many unqualified workers have been prosecuted recently and secondly have such prosecutions only commenced recently?

The paper appears to be implying that QNC’s approach to date appears to have concentrated on the pursuit of the alleged misconduct of individual practitioners rather than addressing more complex systemic issues. Although we acknowledge that a critically component of the QNC’s role includes ensuring the safe practice of individual nurses, we would say that this occurs in a context and this context is not always acknowledged.

### 3.3.2 The Scope of Midwifery Practice

We wish to again highlight to this review that some useful materials regarding the scope of midwifery practice can be found in the research papers produced as part of the current *National Review of Nursing Education*.

### 3.4 Approaches in other jurisdictions

For further analysis on the approach to regulation in other jurisdictions please see the relevant papers produced as part of the current *National Review of Nursing Education*. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled *Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes*

## **4.0 Options**

### **4.1 Options for Nursing**

#### **4.1.1 Option 1 - Title Only**

Not supported.

#### **4.1.2 Option 2 - Title and Core Practice Restriction**

Not supported.

#### **4.1.3 Option 3 – Title and Broad Practice Restriction**

##### **Option 3 A**

Not preferred – needs to be extended. (See Option 3 C below.)

##### **Option 3B**

Not preferred – needs to be extended. (See Option 3 C below.)

##### **Option 3 C – Title and Broad Practice Restriction**

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must contain the necessary exemptions for other regulated health professionals and those with “Nursing” in their position title (eg Assistants in Nursing and Nursing Students) who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council’s powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

## **4.2 Options for Midwives**

### **4.2.1 Option A – Title Only**

Not supported.

### **4.2.2 Option B Title and Core Practice Restriction**

Not preferred. A Title and Core Practice Restriction is Supported, but with the core practices that are restricted must be expanded. See Option C below.

### **Option C Title and (Broader) Core Practice Restriction**

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes “core” midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

### **Specific Questions to Be Answered as Outlined in 4.0 Options (p 23) Which are your preferred options for nursing and midwifery?**

**Nursing:** Our preferred option is new option 3c as outlined above as:

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must

contain the necessary exemptions for other regulated health professionals and those with “Nursing” in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council’s powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

**Midwifery:** – Our preferred option for midwifery is a new C option, a title and (broader) core practice restriction as outline above as:

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes “core” midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

### **What are the reasons for your preferred options?**

**Nursing** -In our view title restriction alone is insufficient to protect the community as it fails to regulate actual nursing practice –ie it ignores those who are undertaking nursing practice under another title. There is a need to regulate unqualified practitioners who are undertaking nursing practice given that the overriding rationale for act is consumer protection. Currently there is a substitution/de-regulation agenda in some areas (eg aged care) that is facilitated by deficiencies in the act and/or limited action by QNC against employers engaged in such activities.

We accept there is a need for better mechanisms that would facilitate the definition of nursing practice, but believe that it would be too complex and restrictive to construe a definition of nursing practice for legislative purposes.

A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

**Midwifery** – We need a broader definition of midwifery practice because there are risks to the consumer at all stages of the confinement not just at the time of Labour. The title of midwife needs to be protected to ensure that persons who are not appropriately qualified do not engage in practices that may endanger a mother or foetus/infant. A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

**Which options do you consider workable or feasible?**

The preferred options stated above are the only ones that we believe are workable and feasible.

**What costs and benefits are there for each option, in relation to your activities/operations and that of other stakeholders?**

We have attempted to quantify the costs and benefits associated with each of the options but have found that this is impossible to do in a meaningful way. We can talk broadly about the issues that need to be considered, but when it comes down to quantifying actual costs and benefits of each option, we question the validity of such an analysis. For example, it is difficult enough identifying opportunity costs associated with each option let alone attempting to determine the full range of possible costs and benefits.

The advantages and disadvantages contained in the discussion paper are acknowledged as being worthy of consideration.

**Where possible, can you estimate the monetary value of the cost or benefit?**

Quantification of costs in dollar terms is extremely difficult given the complexity of the health sector. The main costs would relate to decreased quality of care and hence patient outcomes (eg increase in adverse events, increased length of stay etc) and also increased litigation. Indeed we believe that it is very dangerous and indeed inappropriate to attempt to quantify costs in dollar terms in the absence of a rigorous and agreed methodology for quantifying costs.

**Which options, for both nursing and midwifery, do you consider best meets the objectives of the legislation?**

The options that we have stated are preferred – see above

**In relation to the options for nursing:**

**(a) should the title “nurse” , and derivatives such as assistant in nursing, be restricted to persons authorised under the Act; and**

Yes, we have made submissions to this effect for some time now. This is currently a serious deficiency in the Act. Any person, howsoever termed, undertaking nursing practice needs to be regulated.

**(b) which other titles, if any, should be restricted to only persons authorised under the Act?**

We currently can not identify any other titles that need to be authorised under the act so long as better mechanisms are available to facilitate the determination of whether someone is undertaking nursing practice. (Once determinations are made then these could, for example, be made publicly available on the Internet and in other forms to facilitate public awareness of what constitutes nursing practice. Consumer input into such determinations would also be required so as to ensure that consumer expectations are taken into consideration.) This would ensure that those engaged in nursing practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

**In relation to options for midwifery:**

**(a) should the title “midwife” be restricted to persons authorised under the Act; and**

Yes.

**(b) which other titles, if any, should be restricted to only persons authorised under the Act?**

We currently can not identify any other titles that need to be authorised under the Act. So long as the definition of midwifery practice is extended in line with our definition and there are mechanisms are available to facilitate the determination of whether activities constitute midwifery practice then this should be sufficient. This would ensure that those engaged in midwifery practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

**In relation to option 3B for nursing, how should “nursing practice” be defined in the Act?**

This matter is complex and needs further urgent consideration. It may not be possible to establish a clear definition of nursing practice that is suitable for legislative purposes. This is not to say that mechanisms that facilitate such definitions being

made in an appropriate and timely manner can not be given effect under the act. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

**In relation to option B for Midwifery, is the proposed core practice adequate to ensure that only midwives can practice midwifery activities that carry significant risks if performed by unqualified persons?**

As stated above, we believe that the definition of midwifery practice needs to be broader to ensure consumer safety. Our suggestion is as follows:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (e) *Education and Research.*

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## Summary of QNU Recommendations

Further to the recommendations made in our 2001 submission to this review, the QNU makes the following recommendations:

Recommendation 1: That as part of this review process public input be sought on the threshold issue of the appropriateness of subjecting services such as health (and in this instance nursing) to the application of National Competition Policy.

Recommendation 2: That the Public Benefit Test assessment criteria include those that measure the impact on the Government's Priority Outcomes as well as specific criteria to measure health outcomes.

Recommendation 3: That legislative amendments be made to the *Nursing Act 1992* to require the Queensland Nursing Council to regulate those currently unregulated health care providers who are undertaking nursing practice. (With the proviso that other regulated health providers are exempt from this provision so long as they are working within their profession's scope of practice.)

Recommendation 4: That mechanisms that facilitate the definition of nursing practice be investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

Recommendation 5: That legislative amendments be made to the *Nursing Act 1992* that protect the use of title of nurse and midwife. Further to this, that a title exemption also be given to those with the word "Nursing" in their title (eg Assistant in Nursing" or "Nursing Student") who are working under the direct and indirect supervision of a Registered Nurse.

Recommendation 6: That the current restrictions relating to the provision of a nursing service and nursing practice contained in the *Nursing Act 1992* be retained. (Note: Option 3b does not include the nursing service component.)

Recommendation 7: That the current legislative provisions of the *Nursing Act 1992* be strengthened to enable the Queensland Nursing Council to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

Recommendation 8: That a Title and Broad Practice restriction be adopted (a combination of Options 3A and 3B) that: maintains the current nursing service and practice restrictions. This option (3 C) must contain the necessary exemptions for other regulated health professionals and those with "Nursing" in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained.

Recommendation 9: That the *Nursing Act 1992* be amended to include the following definition of midwifery practice:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

- (a) *Antenatal Care;*
- (b) *Labour (all stages);*
- (c) *Postnatal care of the mother;*
- (d) *Neonatal care; and*
- (f) *Education and Research.*

Recommendation 10: That a Title and Core Practice restriction be adopted for Midwifery and that the definition of the Core Practice include activities outlined in recommendation 9 above.