

Submission to

The Productivity Commission

***Introducing Competition and
Informed User Choice into Human Services:
Reforms to Human Services
Draft Report***

July, 2017

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Productivity Commission (the Commission) for the opportunity to respond to the Human Services Draft Report (the draft report).

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

Our 56,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

In February, 2017, the (then) QNU made a detailed submission to the Commission's inquiry into Reforms to Human Services. Here, we provide a response to some of the recommendations in the draft report.

Summary of Recommendations

The QNMU recommends the Commission works with the Commonwealth to determine reform priorities including:

- increasing access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) for nurses and midwives;
- expanding the list of hospitals eligible for exemption under Section 19(2) of the *Health Insurance Act 1973* to align with growing demands in regional, rural and remote communities;
- developing a national health professional prescribing pathway inclusive of registered nurses and midwives;
- developing an NMBA endorsed program of study that enables RNs and RMs to be educationally prepared and competent to supply medicines to consumers under the PBS as well as request diagnostic tests under the MBS; and
- designing healthcare performance data sets and information systems that collect specific information about the structure, process and quality outcomes of nursing

and midwifery care. In palliative care, minimum data sets should refer to the type of health care provider e.g. registered nurse, the structure and process of care as well as the quality outcomes in similar fashion to aged care standards.

- developing a national public reporting framework on safety and quality that includes primary and aged care.

Further, the QNMU recommends:

- Community-based palliative care should only be undertaken by RNs, NPs and/or medical practitioners;
- Palliative care services should be fully funded commensurate with the level of ICD code Z51.5 for palliative care. This is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. Z51.5 is the code for an encounter for palliative care;
- All RNs and NPs are included in a new Medicare item number for advanced care planning not just practice nurses;
- If an individual is unable to complete an advanced care plan due to reduced cognition, then a 'Statement of Choices', an Enduring Power of Attorney for Health Matters (or similar document) should be considered as an alternative;
- The Commission explores opportunities to provide fiscal incentives through the Aged Care Funding Instrument or aged care pension specifically to authorise an Enduring Power of Attorney;
- The Australian government amends the Aged Care Quality of Care Principles to require residential aged care facilities ensure only *medical practitioners, registered nurses, nurse practitioners* or other registered health professionals hold conversations with residents about their future care needs. This conversation should take place in all situation where a person enters a care arrangement.
- The Commission seeks a review of the relevant legislation around issuing death certificates and extinction of life forms and consults with the Nursing and Midwifery Board Australia (NMBA) to provide guidance on scope of practice for RNs undertaking this task.

The QNMU asks the Commission to recommend governments:

- adopt the 'Health in All Policies' approach to address inequities arising from the social determinants of health;
- investigate the potential of superannuation funds as investors in long term models of funding for housing;
- provide automatic eligibility for bulk billing (health care concession card) for people receiving rent assistance in any form.

Nursing and Midwifery Workforce Reforms to Enhance the Provision of Human Services

The QNMU considers there are significant opportunities for reform in the nursing and midwifery health workforce that will assist the Commonwealth in achieving its primary health care goals and the provision of human services. The continuing failure of the healthcare system to utilise nurses and midwives to their full scope of practice is limiting consumer access to evidence-based, cost-efficient nurse/midwife-led models of care.

Advancing the provision of human services will involve the development and operationalisation of strategies that enable nurses and midwives to:

- work to their full scope of practice across all settings;
- expand the delivery of nursing and midwifery across the healthcare system to increase service capacity and consumer choice;
- increase nursing and midwifery services to improve the effectiveness and efficiency of the healthcare system;
- provide high-performing nursing and midwifery services through continual learning and evidence-based practice; and
- enhance patient/consumer care through access to appropriately designed data sets and information systems (Queensland Health, 2013; Altman et al., 2016; Institute of Medicine of the National Academies, 2010; Coalition of National Nursing and Midwifery Organisations, 2017; Fairman et al., 2011).

A fundamental reform priority is to expand the public/private service provider frameworks and funding models to include registered nurses and midwives, particularly in the areas of PBS, MBS and private insurance schemes. The inclusion of RNs and RMs in public/private service provider frameworks will increase the capacity of healthcare services to meet consumer demand by reducing the preferential financial support for medical models of practice over nursing and midwifery models.

At present, in the majority of healthcare interactions a medical officer must be appointed as the primary healthcare provider if healthcare organisations want to be fully funded for services provided, or if consumers want to obtain full rebates for services received.

The inequitable access to public/private service provider frameworks and funding models has produced perverse financial incentives, which have driven the majority of Australian healthcare services and consumers to only consider medical officers as primary healthcare providers. This bias towards medical officers has resulted in registered nurses and midwives being underutilised in the healthcare system even though evidence indicates they are

capable of providing the same, if not better, outcomes for consumers than their medical colleagues (Queensland Health, 2013; Middleton, et al., 2011; Pearce et al., 2010; Sandall et al., 2016; Wilson et al., 2012; Yates & Aranda, 2013).

An inclusive service provider framework and funding model is possible through the Council of Australian Governments (COAG) ‘improving access to primary care in rural and remote areas Section 19(2) exemption initiative’. This initiative provides for exemptions under section 19(2) of the *Health Insurance Act 1973* to allow eligible sites to claim against the MBS for non-admitted, non-referred professional services, which includes nursing and midwifery services provided in emergency departments and outpatient clinic settings (Queensland Health, 2013). The initiative originated from the need for public hospitals to provide primary health services to rural and remote towns due to the lack of private General Practitioner services (Queensland Health, 2013).

There are many QNMU members working in Queensland Health services that apply the section 19(2) exemption. Queensland has 32 exempt hospitals making it the state with the highest number of exemptions in Australia (Queensland Health, 2013). It is obvious, as the largest clinical workforce, that nurses and midwives are providing significant levels of primary health services to rural and remote Queenslanders (Cliffe & Malone, 2014). These services are considered safe and of high quality. We see no reason why RNs and RMs should not be included in the general MBS and PBS servicing framework.

The table below provides a summary of the projected key benefits that would be produced if nurses and midwives were included more in public/private service provider frameworks and funding models.

Figure 1: The impact of inclusive service provider frameworks and funding models

Healthcare system stressors (Queensland Health, 2013)	Benefits of including nurses/midwives in service provider models (Altman et al., 2016)
Increasing consumer demand	increase in availability of primary healthcare providers improvements in the capacity of healthcare services to meet demand
Increasing consumer expectations	increase in consumer choice decrease in wait times
Increasing burden of chronic disease	increase in consumer access to appropriately skilled healthcare providers increase in the capacity of health promotion and prevention services

Achieving equitable health outcomes	<p>increase in access to healthcare providers in rural & remote communities</p> <p>increase capacity to meet the healthcare needs of Aboriginal & Torres Strait Islanders</p>
Developing a productive health workforce	<p>increase in the productivity of healthcare services</p> <p>increase in the integration of healthcare services</p>
Utilising data and evidence to drive value	<p>provision of evidence-based contemporary healthcare services</p> <p>increase in the effectiveness and efficiency of healthcare services</p>

QNMU Recommendation

The QNMU recommends the Commission works with the Commonwealth to determine reform priorities including:

- increasing access to the MBS and the PBS for nurses and midwives;
- expanding the list of hospitals eligible for the Section 19(2) exemption; and
- developing a national health professional prescribing pathway inclusive of registered nurses and midwives.

End-of-life care

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 4.1

State and Territory Governments should ensure that people with a preference to die at home are able to access support from community-based palliative care services to enable them to do so. To achieve this, State and Territory Governments should:

- assess the need for additional community-based palliative care services;
- design services to address identified gaps in service provision;
- use competitive processes to select providers (or a single provider) to deliver additional community-based palliative care services;
- monitor and evaluate the performance of community-based palliative care services to ensure that those services deliver integrated and coordinated nursing, medical and personal care, and provide access to care and support on a 24 hours a day, 7 days a week basis;
- ensure that consumer safeguards are in place so that quality care is provided, and oversight is maintained, as the volume of services provided increases.

As we have argued in the previous section, removing the barriers to equitable access to public/private service provider frameworks and funding models would increase the utilisation of nurses in the healthcare system including palliative care. Palliative care is a highly specialised area of nursing. These nurses have extensive knowledge and experience in the management of pain and complex symptoms associated with terminal illness. They work collectively and with other professional groups to advance the body of knowledge about end of life care, initiating and conducting research and incorporating research findings into their practice where appropriate (Palliative Care Nurses' Association, 2012).

The care and treatment of a person with a terminal illness must be consistent with the person's beliefs and cultural expectations. People with a terminal illness have the right to access specialist palliative care services including pain management and emotional and psychosocial support in preparation for death.

The QNMU considers the effectiveness of palliative care services relies heavily on early referral for optimal outcomes. Given the ageing population, resourcing for palliative care requires an exploration of service demand now and in the future, and how and where this demand can be best met. This should occur in discussion and collaboration with consumers, their families and health care professionals.

We believe existing service gaps must be filled to meet the demands of the future. This will require, for example, ensuring there is a move to models of care that provide palliative care in existing services (that is, acute and aged care settings) as well as the community. Specialist palliative care services must be better resourced (funding and personnel) and integrated into the community. To that end, there are many opportunities to utilise the nursing workforce more efficiently by removing restrictions that currently limit their capacity to work to their full scope of practice.

We note the Commission has recommended the use of competitive processes to select additional community-based palliative care providers. While we recognise people with a terminal illness have the right to a choice, both in the care and treatment which is provided to them and in the way in which that care and treatment is provided, we contend there is a high risk in privatising public palliative care services. Competitive tendering will inevitably introduce cost-related assessments and this may impact on the type and level of care provided. Continuity of care and professional standards must be key factors in the provision of services to a very vulnerable cohort. Their care and dignity, not profit, are paramount and the use of market forces should be largely excluded.

We promote a high level and standard of nursing for community based palliative care i.e. only RNs or Nurse Practitioners (NPs) should provide this care. Nurses in this specialty area require ongoing access to training and education.

QNMU Recommendation

The QNMU recommends:

- Community-based palliative care should only be undertaken by RNs, NPs and/or medical practitioners;
- Palliative care services should be fully funded commensurate with the level of ICD code Z51.5 for palliative care. This is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. Z51.5 is the code for an encounter for palliative care;
- The commission explores alternative mechanisms for funding additional community-based palliative care rather than competitive bidding for the delivery of this public good.

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 4.3

The Australian Government should promote advance care planning in primary care by:

- including the initiation of an advance care planning conversation as one of the actions that must be undertaken to claim the '75 plus' health check Medicare item numbers. At a minimum, this would require the general practitioner to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan
- introducing a new Medicare item number to enable practice nurses to facilitate advance care planning.

The QNMU welcomes advance care planning (ACP) in primary care. In our view, all RNs and NPs should be included in the new Medicare item number not just practice nurses. RNs and NPs working in aged and community care are well-placed to provide this service, however we point out that ACP requires time and resources. Employers must allow for this in the allocation of workloads for RNs and NPs who undertake this role.

The ACP should be a routine part of a resident's admission process where the clinician documents any instructions in a specific section of individual's file. If an individual is unable to complete an advanced care plan due to reduced cognition, then a 'Statement of Choices', an Enduring Power of Attorney for Health Matters (or similar document) should be considered as an alternative. Service providers will need to consider the impact these additional procedures may have on the clinician's workload.

We ask the Commission to consider exploring opportunities to provide fiscal incentives to authorise an Enduring Power of Attorney. The federal government could enable this by incorporating an additional specific component in the Aged Care Funding Instrument (ACFI) or aged pension that applies when a person is admitted into residential or community care.

QNMU Recommendation

The QNMU recommends:

- All RNs and NPs are included in a new Medicare item number for advanced care planning not just practice nurses;
- If an individual is unable to complete an advanced care plan due to reduced cognition, then a 'Statement of Choices', an Enduring Power of Attorney for Health Matters (or similar document) should be considered as an alternative.

- The Commission explores opportunities to provide fiscal incentives through the ACFI or aged care pension to authorise an Enduring Power of Attorney.

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 4.4

The Australian Government should amend the aged care Quality of Care Principles to require that residential aged care facilities ensure that *clinically trained staff* hold conversations with residents about their future care needs. This should include helping each resident (or their family or carers) to develop or update an advance care plan (or to document that the resident would prefer not to complete an advance care plan) within two months of admission to the facility.

We note the recommendation requires ‘clinically trained staff’ to hold conversations with residents about their future care needs. In our view this needs to be more precisely defined according to the clinical discipline e.g. RN, NP.

We also question why this recommendation only applies in residential aged care facilities. With increasing use of community based care, this conversation should take place in all situations where a person enters a care arrangement.

QNMU Recommendation

The QNMU recommends

- The Australian government should amend the aged care Quality of Care Principles to require residential aged care facilities ensure only *medical practitioners, registered nurses, nurse practitioners* or other registered health professionals hold conversations with residents about their future care needs.
- This conversation should take place in all situation where a person enters a care arrangement.

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 4.5

The Australian, State and Territory Governments should ensure that there are sufficient data to enable governments to fulfil their stewardship functions by monitoring how well end-of-life care services are meeting users’ needs across all settings of care.

Governments should work together to develop and implement an end-of-life care data strategy that leads to the provision of, at a minimum, linked information on:

- place of death;
- primary and secondary diagnoses;
- details of service provision at time of death (what, if any, health or aged care did they receive, at what level and for how long);
- whether they had an advance care plan.

The QNMU believes the development of appropriate nursing and midwifery data sets at the national level will facilitate positive reform for nurses and midwives across the legislative, administrative, funding and policy frameworks. Minimum nursing/midwifery data sets collect specific information about the structure, process and quality outcomes of nursing and midwifery care (Montalvo, 2007; Sermeus et al., 2005). They are often used to demonstrate how nurses and midwives add value in the healthcare system (Montalvo, 2007; Sermeus et al., 2005).

In Australia, healthcare performance data sets are predominately aligned to meet the reporting requirements of generic macro-level funding models (Klynveld, Peat, Marwick, Goerdeler, 2017). The generic nature of these data sets is problematic as the data produced does not adequately represent the contribution of nurses and midwives as the largest clinical workforce (Burston, et al., 2014).

The QNMU considers the development of specifically designed data sets and information systems should be a major reform priority for the nursing and midwifery health workforce. In palliative care, minimum data sets should refer to the type of health care provider e.g. registered nurse, the structure and process of care as well as the quality outcomes in similar fashion to aged care standards. This information will provide evidence to support future billing/funding decisions.

We believe governments may need to review the relevant legislation around issuing death certificates and extinction of life forms and consult with the Nursing and Midwifery Board Australia (NMBA) to provide guidance on scope of practice for RNs undertaking this task.

QNMU Recommendation

The QNMU recommends the Commission:

- Seeks the development of specifically designed data sets and information systems for the nursing and midwifery health workforce. In palliative care, minimum data sets should refer to the type of health care provider e.g. registered nurse, the structure and process of care as well as the quality outcomes in similar fashion to aged care standards;
- Seeks a review of the relevant legislation around issuing death certificates and extinction of life forms and consults with the NMBA to provide guidance on scope of practice for RNs undertaking this task.

Social housing

Broad social, economic and physical factors – known as the social determinants of health – largely shape the health and wellbeing of the population. Most of these are outside the control of the health system. Housing, transport, education and the environment can all affect health and wellbeing. Policies that adopt a shared goal to improve health and wellbeing need to integrate responses that cross all sectors of government and portfolio boundaries (Kickbusch, 2007).

The ‘health and wealth’ agenda is based on the scientific evidence that health is an investment, not just an expenditure. Healthier populations are more productive, participate more actively in the labour market and gain higher incomes (McDaid, Drummond & Suhrcke, 2008; Suhrcke, Lorenzo & McKee, 2007; Suhrcke, McKee, Sauto Arce, Tsoolova & Mortenson, 2005).

Recent European examples of a whole-of-government approach for health in all policies are found in England, Finland, France, the Netherlands, Norway and Sweden. These countries use combinations of governance tools such as policy formulation, target setting, public health laws, cabinet level coordination, interdepartmental committees, horizontal and vertical coordination mechanisms, public hearings, cross-department spending reviews within a relatively coherent government framework (Wismar & Ernst, 2010). They use these tools to reach out to other government departments and sectors to integrate health in other policies.

The *Health in All Policies* initiative demonstrates its value as an approach to collaborative policy development. *Health in All Policies* also provides a framework for meeting the needs of sectors outside of health such as housing as well as long term population health and wellbeing goals. This reflects the idea of reciprocity, one of the key philosophies underpinning the initiative.

Cross-sector collaboration and partnerships have been recognised as important system building strategies. Mechanisms to support and systematise these practices across state and local government help to ensure ongoing action to address the social determinants of health and improve the population’s health and wellbeing (Government of South Australia, 2013).

Adequate housing provides critical infrastructure essential to wellbeing, social and economic participation and the sustainability of communities. A lack of affordable housing for rent and purchase has impacts across the community, in particular for:

- Women who are vulnerable to housing stress and homelessness, as a result of lower wages, overrepresentation in casual and part-time employment, interruptions to workforce participation, and their making up the majority of sole parent and single person households.
- Single parent households who make up almost 16% of all households 8.
- Young people who face particular challenges meeting their basic needs and experience difficulties in accessing and sustaining tenancies due to discrimination and poverty.
- People with a disability and their carers who are 36% more likely to experience housing stress compared to the general population¹⁰. This is because of a lack of appropriate housing, high costs of relocation and lower earning capacity.
- Aboriginal and Torres Strait Islander people who are over-represented amongst those experiencing homelessness, struggling to access housing and residing in overcrowded dwellings.
- People from culturally and linguistically diverse (CALD) backgrounds who experience difficulty in obtaining and sustaining suitable housing.
- Older people who are increasingly vulnerable to housing stress and homelessness due to their fixed incomes (Dufty-Jones & Rogers, 2015; Queensland Department of Housing and Public Works, 2016)

These challenges are faced by a significant proportion of our population and create additional demand on housing. To address the inherent health problems associated with lack of proper housing, the QNMU advocates for automatic eligibility for bulk billing (health care concession card) for people receiving rent assistance in any form.

We recognise that governments need to provide extensive funding for public housing. In our view, there is scope to consider superannuation funds as investors in long term models of public housing.

QNMU Recommendation

The QNMU asks the Commission to recommend governments:

- adopt the 'Health in All Policies' approach to address inequities arising from the social determinants of health;

- investigate the potential of superannuation funds as investors in long term models of funding for housing;
- provide automatic eligibility for bulk billing (health care concession card) for people receiving rent assistance, in any form.

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 5.2

State and Territory Governments should abolish the current assistance model for social housing where rents are set at a proportion of the tenant's income and enhance user choice by:

- providing a high-cost housing payment funded by State and Territory Governments for eligible tenants, such as those with a demonstrated need to live in a high-rent area;
- delivering the high-cost housing payment to the tenant in a way that would enable it to be used in either the social or private rental markets;
- offering existing tenants in social housing an option between continuing to pay rent set at a proportion of their income for up to ten years, or electing to move to the new assistance model;
- charging market rents for tenants in social housing.

The QNMU does not support abolishing the current rent assistance model. User choice models may benefit some, but we see a high risk that those who a high-cost housing payment but cannot maintain their income may find themselves driven into homelessness.

Strata payments should be commensurate with the annual average rental price in the location and indexed to inflation annually for longer term tenants

We do not support the ten year limit on existing social housing or charging market rents for tenants in social housing. These changes may be suitable if a person's circumstances improve to the point they can afford to move into or buy another residence, but for many, it may mean a huge upheaval at a time in their life when they are ageing and/or have limited accommodation options in the same area.

Services in remote Indigenous communities

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 8.4

When selecting providers of human services in remote Indigenous communities, the Australian, State and Northern Territory Governments should take into account the attributes of providers that contribute to achieving the outcomes sought. This may include:

- culturally appropriate service provision (specific to the region where the service is being delivered);
- community engagement and governance (including through considering communities' feedback on provider performance);
- collaboration and coordination with existing service providers, and community bodies;
- employment and training of local and/or Indigenous staff.

In Queensland, the most serious gaps in the primary health system exist for patients requiring highly specialised and diverse health care such as patients experiencing mental illness, particularly in the category of child and youth, disability and domestic violence. Service gaps in primary health care are more prominent in indigenous communities as demonstrated by the limited progress against the child mortality and life expectancy targets reported within the *Closing the Gap Prime Ministers' Report 2017* (Australian Government, 2017). According to the report:

The target to halve the gap in child mortality by 2018 was not met in 2016. The 2015 Indigenous child mortality rate is just outside the range for the target. Over the longer-term (1998 to 2015), the Indigenous child mortality rate declined by 33 per cent. The child mortality gap narrowed (by 31 per cent) over the same period. Continued improvements in key factors which influence the health of Indigenous children, such as access to antenatal care and rates of smoking during pregnancy, have the potential to support the achievement of this target by 2018.

The target to close the gap in life expectancy by 2031 has not been met either based on data since the 2006 baseline.

Over the longer term, the total Indigenous mortality rate declined by 15 per cent between 1998 and 2015, with the largest decline from circulatory disease (the leading cause of

Indigenous deaths). However, the Indigenous mortality rate from cancer (the second leading cause of death) is rising and the gap is widening (Australian Government, 2017).

The reasons for service gaps in the primary health care system include but are not limited to:

- Lack of health service integration;
- Limited patient coordination;
- Inability for clinicians to work to full scope;
- Limited access to the Medical Benefits Scheme (MBS) for nurses/midwives;
- Inadequate health workforce planning;
- Ineffective health policy/strategic direction;
- Insufficient funding/prioritisation;
- Minimal evaluation and public reporting;
- Geographical location.

To address the service gaps in Indigenous communities, nurse/midwife led models are essential. Nurses and midwives are the most geographically dispersed health care providers who are well qualified to deliver high quality health programs.

As we have stated, the inclusion of RNs and RMs in public/private service provider frameworks will increase the capacity of healthcare services to meet consumer demand by reducing the preferential financial support for medical models of practice over nursing and midwifery models of care.

The exemptions under section 19(2) of the *Health Insurance Act 1973* allowing eligible sites to claim against the MBS for non-admitted, non-referred professional services includes nursing and midwifery services provided in emergency departments and outpatient clinics. It originated from a need for services in rural and remote areas. Nurses and midwives are currently providing safe, high quality services in these communities and should be included in the general MBS and PBS servicing framework.

Rural and Isolated Practice Endorsed Registered Nurse (RIPERN)

Rural and remote communities would also benefit from greater use of RIPERNS and NPs. A RIPERN is a registered nurse who has met the Nursing and Midwifery Board of Australia (NMBA) registration standard for endorsement for scheduled medicines – rural and isolated practice (Sermeus et al., 2005). RIPERNS may practise in isolation or in collaboration with other health professionals in areas such as rural and remote hospitals, remote area emergency sites, mining sites, indigenous communities, tourist resorts, and remote pastoral stations. Predominately, RIPERNS work in locations where onsite access to medical practitioners and/or nurse practitioners is by visit only or not available at all.

The RIPERN endorsement, as per Section 94 of the *Health Practitioner Regulation National Law Act 2009* (the National Law) qualifies a RIPERN to obtain, supply and administer limited schedule 2, 3, 4 or 8 medicines appropriate to their scope of practice. This is to the extent necessary to practise nursing in a particular area and within the confines of a Chief Health Officer standing order or health services permit that must be compliant with relevant State and Territory legislation (Sermeus et al., 2005). The services provided by RIPERNS meet the eligibility criteria for the MBS and the PBS.

In Australia, there are approximately 1,100 RIPERNS endorsed to provide emergency and primary healthcare to an advanced and/or expanded clinical scope of practice to patients in rural and remote areas (Klynveld, Peat, Marwick, Goerdeler, 2017). Queensland has the largest number of RIPERNS with 836 found on the register (Klynveld, Peat, Marwick, Goerdeler, 2017). In 2016, the NMBA proposed the discontinuation of the *Registration standard: Endorsement scheduled medicines (rural and remote practice)*. The outcome of NMBA's proposal is still pending; however, the QNMU strongly opposes the discontinuation of this endorsement, as it places Queensland's rural and remote primary healthcare services at risk of not being able to meet the health demands of their communities.

RIPERNS contribute to public safety and provide evidence-based quality care for people living and working in rural and remote communities across Queensland (Currie, et al., 2016). The withdrawal of this endorsement would significantly reduce the numbers of staff available to supply medicines in these vulnerable locations. An alternative solution to the loss of RIPERNS is transition to nurse practitioner positions.

NPs have access to MBS and PBS and are capable of providing high levels of clinically focused autonomous nursing care in a variety of contexts in response to varying patient/community complexities (Burston, et al., 2014). The contribution of NPs to the healthcare system is extensive and well proven (Middleton et al., 2013). However, workforce mapping in Queensland has demonstrated there are insufficient numbers of NPs to replace the RIPERN positions presently employed. This is due to the lengthy time it takes for NPs to become educationally prepared and competent for practice. We see a role for both types of nurses.

Midwifery

In January 2017, the standard for 'eligible' midwives was altered to create a one-step process requiring all midwives who seek a Medicare provider number to obtain an endorsement for scheduled medicines (Nurses and Midwifery Board Australia, 2017). The 130 midwives who were notated as 'eligible' are now required to join the 278 midwives who have an 'endorsement for scheduled medicines' (Nursing and Midwifery Board Australia,

2017). This transition must occur within 18 months or the 'eligible' midwives will lose their ability to access a Medicare provider number. However, the motivation for 'eligible' midwives to undertake coursework to become 'endorsed' is low as the vast majority of these midwives are employed within state healthcare services where they are unable to use their endorsement due to restrictive models of maternity care.

The mechanism to enable use of the MBS by midwives exists using the Section 19(2) exemption pathway model as outlined above for nurses. If applied more broadly, the exemption pathway would allow midwives providing primary maternity care to increase the funding prospects for healthcare services through 'own source' revenue models. 'Own source' revenue models for midwifery services have been recognised by a number of national maternity care reviews as a viable funding option for health services.

The QNMU considers the failure of the healthcare system to utilise midwives to their full scope of practice is limiting consumer access to evidence-based maternity models of care in rural, remote and other communities. This is an area critically in need of reform.

QNMU Recommendation

To support the sustainability, continuity and quality of healthcare in rural and remote communities, the QNMU believes the following fundamentals are necessary:

- the existence of an NMBA endorsed program of study that enables registered nurses and midwives to be educationally prepared and competent to supply medicines to consumers under the PBS, as well as, request diagnostic tests under the MBS;
- the list of rural and remote hospitals eligible for the Section 19(2) exemption requires expansion to align with growing demands within regional, rural and remote communities; and
- the development of a national health professionals prescribing pathway inclusive of core prescribing competencies for registered nurses.

Public Hospital Services

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 9.1

The Australian Government should amend the Health Insurance Regulations 1975 to make it clearer that patients referred to a specialist can choose the public outpatient clinic or private specialist they attend for their initial consultation. This includes clearly specifying that:

- referrals do not need to name a particular clinic or specialist;
- any specialist can accept a referral to a specialist of their type, irrespective of whether another person is named as the specialist in the referral;
- when making a referral to a specialist, general practitioners (GPs) must explain to patients that they can attend a specialist or public outpatient clinic other than the one named in the referral, and patients can choose independently after receiving support and advice from their GP at the time of referral;
- referral letters should clearly indicate that patients must be offered choice by their GP, can attend a specialist or clinic other than the one named in the referral, and can choose independently after receiving the referral.

The QNMU supports this recommendation. In our view, referrals for chronic/long-term illness should be open-ended. In these cases, consumers should not be required to seek ongoing referrals.

Rural and remote consumers face high costs when accessing specialist treatment in the city. Governments should review patient subsidies regularly and provide adequate funding. One option for consideration is strata payment commensurate with geographical isolation that is indexed to inflation annually.

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 9.2

The Australian Government should develop, with general practitioners (GPs), best-practice guidelines on how to support patient choice. These should form part of a broader strategy — designed with the relevant professional bodies — to help GPs, specialists and other health professionals implement the amendments to the Health Insurance Regulations 1975 in draft recommendation 9.1.

The Australian government would support patient choice to its greatest effect if NPs, midwives and RNs were able to work to their full scope of practice. To enable this, nurses and midwives need equitable access to MBS and PBS. Service types should be consumer focused rather than provider focused for example instead of referring to antenatal care as ‘ante-natal obstetric care’, the service type should be ‘antenatal service’, thus enabling qualified and experienced midwives to provide a service as well as obstetricians.

Information to support patient choice and performance improvement in hospitals

PRODUCTIVITY COMMISSION DRAFT RECOMMENDATION 10.1

The Australian, State and Territory Governments should strengthen and expand their commitment to public reporting in the National Health Reform Agreement to better support patients and their general practitioners to exercise patient choice, and encourage performance improvement by hospitals and specialists. This should include a commitment by all jurisdictions to:

- provide data and other assistance to the Australian Institute of Health and Welfare (AIHW) to enable it to strengthen the MyHospitals website as a vehicle for supporting patient choice and provider self-improvement, as detailed in draft recommendation 10.2;
- adopt a general policy of publicly releasing any data that a jurisdiction holds on individual hospitals and specialists unless it is clearly demonstrated that releasing the data would harm the interests of patients;
- make the information that a jurisdiction publicly releases on hospitals or specialists available in a format that other organisations can readily incorporate in advisory services they provide.

To facilitate reporting on individual specialists, there should also be a commitment by:

- the Australian Government to amend the *Health Insurance Act 1973* (Cwlth) so that medical specialists are required to participate in public information provision, as specified by the AIHW;
- the State and Territory Governments to oblige all specialists serving public patients in their jurisdiction to participate in public information provision, as specified by the AIHW.

There is solid evidence public reporting stimulates quality improvement activities, particularly at hospital level (Fung, Lim, Mattke, 2008; Ketelaar, Faber, Flottorp et al., 2011). However, publishing data about a health system is not helpful if that data is incomplete, inaccurate, out-of-date, or not comparable. The wrong conclusions will be drawn and inappropriate actions taken (KPMG, 2017). Transparency needs to be properly managed if it is to deliver its future potential.

In a recent research report (2017) that examined global health systems, Klynveld Peat Marwick Goerdeler (KPMG) identified the following key actions for governments and providers to increase public reporting in order to reduce costs and improve the quality of health care:

- Develop a whole-system approach to transparency with a positive policy and legislative environment, underpinned by governance focused on quality of care;
- Legislate to measure and report quality of healthcare data including patient experience and PROMS, at unit and provider level;
- Ensure communication of care quality data is accessible, understandable and up-to-date;
- Publicly set out the individual rights of patients;
- Ensure there is public reporting of adverse events;
- Establish a clear patient complaints system.

Key actions for providers:

- Measure and report patient experience data;
- Establish and publish a policy to protect whistleblowers (staff who report concerns about the quality or safety of healthcare) from any negative repercussions;
- Ensure communication of care quality data is accessible, understandable and up-to-date (KPMG, 2017).

The QNMU believes the development of appropriate nursing and midwifery data sets at the national level will facilitate positive reform for nurses and midwives across the legislative, administrative, funding, policy and custom and practice frameworks. Minimum nursing/midwifery data sets collect specific information about the structure, process and quality outcomes of nursing and midwifery care (Montalvo, 2007; Sermeus et al., 2005). They are often used to demonstrate how nurses and midwives add value in the healthcare system (Montalvo, 2007; Sermeus et al., 2005).

In Australia, healthcare performance data sets are predominately aligned to meet the reporting requirements of generic macro-level funding models (Klynveld, Peat, Marwick, Goerdeler, 2017). The generic nature of these data sets is problematic, as the data

produced does not adequately represent the contribution of nurses and midwives as the largest clinical workforce (Burston, et al., 2014).

The QNMU considers the development of specifically designed data sets and information systems should be a major reform priority for the nursing and midwifery health workforce (Queensland Nurses' Union, 2015).

In our view there is also a need for much greater transparency in public reporting in all sectors. We welcome the recent announcement by the Queensland Minister for Health and Minister for Ambulance Services to seek community and professional feedback on their expectations of public reporting in both the public and private sectors. We note the Victorian government has introduced a bill into the parliament¹ that aims to strengthen and elevate roles and responsibilities for quality and safety, improve governance arrangements for public hospitals, public health services and multi purpose services and require health service establishments to comply with health service establishment premises guidelines.

This is a responsibility that does not lie solely with the States. There is also a role for the Commonwealth to develop a national reporting framework on safety and quality in primary and aged care to inform the public of compliance with legislation and standards.

QNMU Recommendation

The QNMU recommends the

- Commonwealth designs healthcare performance data sets and information systems that collect specific information about the structure, process and quality outcomes of nursing and midwifery care.
- Commonwealth develops a national public reporting framework on safety and quality that includes primary and aged care.

¹ See the *Health Legislation Amendment (Quality and Safety) Bill 2017*

References

- Altman, S., Butler, A. & Shern, L. (2016) *Assessing Progress on the Institute of Medicine Report - The Future of Nursing*, National Academic Press (US), Washington.
- Australian Government (2017) *Closing the Gap Prime Minister's Report*, Australian Government, retrieved from <http://closingthegap.pmc.gov.au/sites/default/files/ctg-report-2017.pdf>
- Burston, S., Chaboyer W. & Gillespie, B. (2014) 'Nurse-Sensitive Indicators Suitable to Reflect Nursing Care Quality: a review and discussion of issues', *Journal of Clinical Nursing*, vol. 23, no. 13-14, pp. 1785-1795.
- Cliffe C. & Malone, g. (2014) 'A Framework for Remote and Isolated Professional Practice', Council of Remote Area Nurse of Australia (CRANaplus).
- Coalition of National Nursing and Midwifery Organisations (2017) *Coalition of National Nursing and Midwifery Organisations National Priorities*, Coalition of National Nursing and Midwifery Organisations, Melbourne.
- Currie, F., Nielsen, G., Ervin, K. & Koschel, A. (2016) 'The Value of Rural Isolated Practice Endorsed Registered Nurses in a Small Rural Health Service', *Research in Health Science*, vol. 1, no. 1, pp. 58-67.
- Dufty-Jones, R., & Rogers, D. (2015) *New cabinet, a new approach to housing*, retrieved from <http://www.domain.com.au/news/new-cabinet-a-new-approach-to-housing-academics-20150922-gjrvgh/>
- Fairman, J., Rowe, J., Hassmiller, S. & Shalala, D. (2011) 'Broadening the Scope of Nursing Practice', *The New England Journal of Medicine*, vol 364, no. 3, pp. 193-196.
- Fung, C., Lim Y. & Mattke S. (2008) 'Systematic review: The Evidence that Publishing Patient Care performance Data improves Quality of Care', *Annals of Internal Medicine*, vol. 148, no. 2, pp. 111-123.
- Institute of Medicine of the National Academies (2010) *The Future of Nursing: Leading Change, Advancing Health Report Recommendations*, Institute of Medicine of the National Academies, Washington.

- Ketelaar N., Faber M., Flottorp S., Rygh, L., Deane, K & Eccles, M. (2011) *Public Release of Performance Data in Changing the Behaviour of Healthcare Consumers, Professionals or Organisations*, Cochrane Database Systematic Review.
- Kickbusch, I. (2007) *Healthy Societies: Addressing 21st Century Health Challenges*, Government of South Australia, Adelaide.
- Klynveld Peat Marwick Goerdeler (KPMG) (2017) *Through the Looking Glass: A Practical Path to Improving Healthcare Through Transparency*, KPMG International.
- McDaid, D., Drummond, M., & Suhrcke, M. (2008) *How Can European Health Systems Support Investment in and the Implementation of Population Health Strategies?*, World Health Organization on behalf of the European Observatory on Health Systems and Policies.
- Middleton, S., Gardner, A., Glenn G. & Della, P. (2011) 'The Status of Australian Nurse Practitioners: The second census', *Australian Health Review*, vol. 35, no. 4, pp. 448-454.
- Montalvo, I. (2007) 'The National Database of Nursing Quality Indicators', *The Online Journal of Issues in Nursing*, vol. 12, no. 3, Manuscript 2.
- Nursing and Midwifery Board of Australia (2017) *Registration Standard: Endorsement for scheduled medicines for midwives* retrieved from <http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-for-midwives.aspx>. [Accessed 27 May 2017].
- Palliative Care Nurses' Association (2012) *Submission to Parliamentary Committee Inquiry into palliative care services and home and community care services in Queensland* retrieved from <http://www.parliament.qld.gov.au/documents/tableOffice/CommSubs/2013/PalCareHAAL/046.pdf>
- Pearce, D., Hall S. & Phillips, D. (2010) 'When Policy Meets the Personal: General Practice Nurses in Australia' *Journal of Health Services Research and Policy*, vol. 152, pp. 26-34.
- Queensland Department of Housing and Public Works (2016) *Working together for better housing and sustainable communities*, Queensland Government, Brisbane.

- Queensland Health (2013) *Strengthening Health Services Through Optimising Nursing Strategy and Action Plan (2013-2016)*, Queensland Health, Brisbane.
- Queensland Nurses' Union (2015) *Ratios Save Lives: A care guarantee for the delivery of safe, high quality nursing and midwifery to all Queenslanders*, Queensland Nurses' Union, Brisbane.
- Sandall, J., Soltani, H., Gates, S., Shennan A. & Devane, D. (2016) 'Midwife-led Continuity Models Versus Other Models of Care for Childbearing Women', *Cochrane Database of Systematic Reviews*, no. 4.
- Sermeus, W., Heede, K., Michiels, D., Delesie, L, Thonon, O., Van Boven, C., Codognotto J. & Gillet, P. (2005) 'Revising the Belgian Nursing Minimum Dataset: from concept to implementation', *International Journal of Medical Informatics*, vol. 74, pp. 946-951.
- Suhrcke, M., Lorenzo, R. & McKee, M. (2007) *Health: A Vital Investment for Economic Development in Eastern Europe and Central Asia*, World Health Organization on behalf of the European Economy Observatory on Health Systems and Policies, Copenhagen.
- Surhcke, M., McKee, M., Sauto Arce, R., Tsokova, S. & Mortenson, J. (2005) *The Contribution of Health to the Economy in the European Union*, World Health Organization on behalf of the European Economy in the European Union, Office for Official Publications for the European Communities, Luxembourg.
- Wilson, A., Whitaker, N. & Whitford, D. (2012) 'Rising to the Challenge of Health Care Reform with Entrepreneurial and Intrapreneurial Nursing Initiatives', *The Online Journal of Issues in Nursing*, vol. 17, no. 2.
- Wismar, M. & Ernst, K. (2007) 'Health in All Policies in Europe' in Kickbusch, I. & Bucket K. eds (2010) *Implementing Health in All Policies*, Adelaide, Department of Health, Government of South Australia, pp. 53-65.
- Yates, P. & Aranda, S. (2013) '40 Years of Cancer Nursing in Australia: The Emergence of a Specialty', *Cancer Forum*, vol. 37, no. 1, pp. 35-38.