



Submission to The Productivity Commission

Reforms to Human Services

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Introduction

The Queensland Nurses' Union (QNU) thanks the Productivity Commission (the Commission) for providing the opportunity to comment on the application of competition and user choice to services within the human services sector and policy options to improve outcomes.

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

Our more than 54,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNU.

Our submission provides general answers to the requests for information identified in the *Reforms to Human Services Issues Paper* (the issues paper) concentrating on public hospitals and end-of-life care. We continue to express our concern about the moves towards competition, contestability and user choice in the provision of these important human services.

Recommendations

The QNU recommends:

- The Commission investigates the implementation of a financial transactions tax at rates of around 0.05% (5 cents for every \$100 being traded) as a fairer means of raising revenue to support the upkeep and expansion of government owned services and assets.
- Greater regulation and accountability, not less, in key areas of aged care including:
 - requiring residential aged care providers to employ adequate nursing staff based on a methodology that incorporates the time taken for both direct and

indirect nursing, personal care tasks, assessment of residents, the level of care required by residents and a skills mix of RN 30%, EN 20% and PCW/AIN 50% as the minimum (Willis et al., 2016);

- improving transparency and accountability in government funding and consumer payments; and
- licensing of all workers providing nursing in aged care, including AINs/personal carers irrespective of the job title their employer might give them;
- securing a greater wages share for nurses employed in aged care, who, since the Howard Coalition Government's first round of deregulation in the late 1990s, now earn considerably less than their colleagues in the hospital sector.

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Whether and how, greater competition or contestability could lead to improvements in the quality, equity, efficiency, responsiveness and accountability of service provision.

Role of Government

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

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

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

The drivers/causes of privatisation in Australia

The outdated ideology informing privatisation can be found in the Thatcher and Reagan years where the oil price shock of the 1970s enabled them to implement an ideological agenda, rather than simply address the specific issues and problems of the time. The Abbott government applied this same strategy by using the post - global financial crisis (GFC) debt and deficits to attack national values and expectations of fairness and balance. It is an obsolete approach and one that demonstrates a preference for looking backwards rather than determine a vision for the future.

The impetus for privatisation both nationally and in Queensland has been justified on the back of coalition/LNP government 'audit commissions', a predictable and expensive strategy to convince the electorate there is a 'debt crisis'.

As economist Professor John Quiggin (2013) presciently noted prior to release of the national audit commission's reports:

Advocates of commissions have learned nothing, and forgotten nothing, since Kennett's audit 20 years ago, which in turn reflected the political orthodoxy of the 1980s, based on microeconomic reform, privatisation and financial deregulation.

When commissions of audit began, there was a lot of excitement about new ways to involve the private sector in the provision of public services, epitomised by the hit American book of the time *Reinventing Government*. Some of those ideas, such as competitive tendering, have worked reasonably well, even if not up to their promoters' expectations. Others, such as PPPs, have been disasters, to the point that even insiders like Lend Lease have described the model as 'broken'.

In all probability, none of this experience will be reflected in the commission's report when it is released in January. Instead of a road map for Australian government in the 21st century, we will see the ideology of the 1990s used to support one last push for the policy agenda of the 1980s.

After a couple of decades we have had time to assess these market-based policies and it is obvious they have a mixed record. The appalling conduct of financial institutions led to the GFC and the need for governments to step in to resolve the market-created disaster.

There have been many "market" or private sector failures where governments have had to resume control of public hospitals, private road projects going bankrupt and the collapse of

ABC Child Care, to mention just a few. Rural and regional Australians know they would have limited community services if they relied on “markets” to deliver them.

The QNU rejects the premise that markets are the starting point for public policy and that the private sector will deliver greater efficiencies. Human rights are the starting point for good public policy. Governments have a vital role to play in providing the infrastructure to support the needs of Australians. Governments can also run many programs and risk-management systems more equitably and cost-effectively for society as a whole than the private sector. Included in this are public hospitals, schools and universities.

Therefore governments can and must continue to play a major part in making life fairer and more secure for all, not just the “most” disadvantaged, the term now creeping into political discourse. In many areas such as healthcare and schooling, governments provide important quality services for everyone, not just a safety net. The sale of publicly owned assets or increased private sector ‘competition’ to provide infrastructure is a poor policy response to undertaking a fundamental role of government.

Public Hospital Funding

An area of particular concern is the federal government’s retreat from the agreed funding arrangements with the State and Territory governments under the National Health Reform Agreement initially announced in the 2014-15 budget. The federal government continues to urge the States and territories to drive productivity and efficiency improvements in public hospitals to rein in expenditure growth. From 2017-18 the federal government will introduce revised funding arrangements for public hospitals that remove funding guarantees.

These measures will achieve cumulative savings to the federal budget of over \$80 billion by 2024-25 – but the \$80 billion represents funding withdrawn from the states. The federal government will also reduce or terminate some Commonwealth payments including:

- National Partnership Agreements on Preventive Health;
- Improving Public Hospital Services; and
- Certain concessions for pensioners and seniors card holders.

The States will be expected to continue contributing to these arrangements at their own expense.

In setting out the services that the Commonwealth will fund, Schedule A to the *National Health Reform Agreement* (Council of Australian Governments, 2011) refers to hospital services, teaching and training functions, research funded by states in public hospitals and public health activities managed by states.

The QNU believes that the controversy around public hospital funding **may** be moderated by Activity Based Funding (ABF) since its introduction from 1 July, 2014 **if** the federal government maintains these funding arrangements. Under this arrangement, the Commonwealth will fund 45% of efficient growth of activity based services increasing to 50% from 1 July, 2017. Efficient growth consists of:

- The national efficient price for any changes in the volume of services provided (determined in Schedule B); and
- The growth in the national efficient price of providing the existing volume of services (Council of Australian Governments, 2011, p.13).

The crucial issue is how the national efficient price is defined. In our view, the methodology does not adequately incorporate the true cost of nursing and midwifery services. Queensland Health (QH) has an industrially mandated and validated tool known as the Business Planning Framework (BPF) for matching supply and demand in nursing and midwifery. However, the QNU experiences ongoing difficulty in ensuring QH implements this tool properly.

The Issues paper asks if there are lessons from previous reforms in Australia and overseas to introduce greater competition and contestability in human services provision. In that context, it is worthwhile reflecting on some recent political history to understand the depth of feeling around the sale of public assets and privatisation of services in Queensland all under the ideas of ‘competition’, ‘contestability’ and ‘user choice’.

The Abbott Government

In October, 2013, the federal Treasurer, Joe Hockey, and the Minister for Finance, Senator Mathias Cormann (Hockey & Cormann, 2013), announced a National Commission of Audit to “review and report on the performance, functions and roles of the Commonwealth government”. The National Commission of Audit (the audit commission) released two reports (2014a, 2014b) recommending significant cuts to spending on healthcare, education, unemployment benefits and pensions, aged care, child care, family payments and the new National Disability Insurance Scheme (NDIS).

Under its terms of reference, the Abbott government gave the audit commission clear instructions to recommend ways to achieve its ideological objectives of reducing the role and functions of government and to reach a surplus target of one per cent of GDP within the next ten years.

The audit commission’s reports marked the beginning of a wide-ranging agenda to change Australia through economic policy based on neo-liberal principles of small government and

large private interests. Queensland under the Newman government chose the same trajectory.

The Newman Government

Privatisation has become a deeply divisive issue in Queensland and is fundamentally unpopular with the electorate here and elsewhere.¹ The Newman Government was elected on a promise not to sell assets without going back to the electorate seeking a mandate to do so. This came on the back of the previous Labor Bligh government's plans to sell public assets which was one of the reasons for its crushing election defeat in 2012.

Shortly after it was elected early in 2012, the Newman Government established a Commission of Audit chaired by Peter Costello.² The Newman government used the Queensland Commission of Audit reports to justify widespread cuts to programs and services, privatisation and asset sales.

On election, the Newman Government:

- closed and sold state schools and school grounds; and
- sold government buildings in the Brisbane CBD. As a result of these sales, the government had to rent the buildings it previously owned. An Auditor General report determined that these assets were sold below market value.³

Under the belief that it was not in the business of providing primary health care, the Newman government also:

- closed and sold aged care homes such as Moreton Bay Nursing Care Unit;
- closed and sold public hospitals, such as the Wynnum Hospital;
- closed sexual health prevention services;
- sacked school nurses;
- introduced 'contestability' of health service delivery.

The LNP government's Commission of Audit catastrophised the state of the government's finances and proposed a radical privatisation agenda for the Queensland public sector. The

¹ See, for example, NSW poll results in June 2014 that indicated an 'overwhelming' opposition to privatising the NSW electricity industry: <http://stoptheselloff.org.au/polling-reveals-overwhelming-opposition-electricity-privatisation-regional-nsw/>

² The Commission of Audit presented an Interim Report in June 2012, followed by a Final Report in February 2013.

³ See 'Queensland Government buildings sold at \$226m loss to save \$130m in interest': <http://www.couriermail.com.au/news/queensland/queensland-government-buildings-sold-at-226m-loss-to-save-130m-in-interest/story-fnihsrf2-1226709359186>

LNP's *Blueprint for Better Healthcare in Queensland* outlined the privatisation agenda in Queensland Health.

One of its first tasks was to ask the consulting firm KPMG to consider whether private operators should run the Sunshine Coast University Hospital and the Queensland Children's Hospital. The LNP government tried to obscure the reality of the privatisation and cuts agenda by describing its actions as "contracting out", "contestability", "public private partnership", "renewal" and "delimiting". The federal coalition was full of praise for the Queensland LNP government and echoed support for privatisation in health.

The Newman government itself paid the ultimate political price when it chose to continue with its privatisation agenda in the face of widespread opposition.

The QNU rejects the basic assumptions on the role of government put forward by the audit commissions and the attempt to refashion the Australian economy and society through the privatisation of state and territory assets. The QNU believes government has a vital and effective role to play in the delivery of quality, cost effective universal services.

Privatisation in Health Care

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

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

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

Putting health care on a sustainable footing will require reforms to make the system more efficient and competitive. The supply of health services must increase in line with growth in demand and improvements in productivity are a natural way of ensuring this. More deregulated and competitive markets, with appropriate safeguards, have the greatest potential to improve the sector's competitiveness and productivity.

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

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

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

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

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

We recognise the recommendations were made within the context of competition policy, however we strongly oppose the elevation of market based principles in health service delivery at the expense of government in providing free at point of service, high quality, accessible health care. This is especially problematic given the lack of meaningful, publicly available information for citizens/consumers about the quality of the services being provided. The guiding principles appear to be premised on a fundamental acceptance that competition will automatically deliver better outcomes for Australians regardless of the sector.

We reject this notion, in particular the claim that 'user choice should be placed at the heart of service delivery'. **Quality and safety** are at the core of health service delivery, not user choice, and it is the role of government to fund and provide them.

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

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

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

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

Cases of privatisation in health facilities in Australia

Various state governments have experimented with privatisation of hospitals and it has been less than successful in most cases. State Parliamentary Committees and Auditors General have conducted a number of reviews of private sector provision of public services. These include the Port Macquarie Base Hospital, the first arrangement whereby a private operator (Health Care of Australia) was contracted to provide public hospital services, Modbury Hospital in South Australia, Noosa and Robina Hospitals in Queensland, and Joondalup Hospital in Western Australia (Senate Community Affairs References Committee, 2000)

The reviews identified a range of deficiencies in the contractual arrangements including problems with data and modelling used to compare private and public options, lack of tangible benefits to the state, limited government control over quality, cost overruns, poor contracting management and increased risk for the state (Senate Community Affairs References Committee, 2000).

The following case studies demonstrate the difficulties that can arise when governments contract out the provision of essential services.

Port Macquarie Hospital, NSW

The privatisation of the public hospital in Port Macquarie was the first in Australia and has become a prime example of the failure of corporate privatisations. This case aroused intense debate and opposition both in the parliament and in the community. The NSW government proceeded in the face of objections by the majority of parliamentarians and Port Macquarie citizens. This was to be the first of a large number of public hospital projects which the government planned to sell off.

The government compared the costs of a new public hospital with those of allowing the private sector to build and operate a public hospital. Under the private option it was expected that the new facility would cost \$15 million less and that operational costs over 20 years would also be \$46 million less than for public sector operation.

This assessment was examined by the NSW Public Accounts Committee (PAC) that concluded there was no significant difference in operational costs of providing patient care either through the private or the public sector. It recommended the private sector should be allowed to build the hospital, but that the NSW Government should keep the delivery of hospital services in public hands by leasing the hospital from the private sector.

The PAC recommendations were not accepted. In 1992, the then NSW Government contracted Health Care of Australia (HCOA) to construct and manage a new privately operated 161 bed public hospital owned by Port Macquarie Base Hospital Limited, which was leased to HCOA. The buildings would revert to HCOA after 20 years. In exchange, the NSW Health Department would pay the private operator an annual service charge for the treatment of public patients.

In 1996, the NSW Auditor General reported that the final costs had increased significantly over those contained in the tender documents. In addition, the Health Department did not have accurate costing systems to identify reliably the costs of operating an individual hospital at a particular level of service delivery. Thus the output of the model of public sector operation it had used to compare with the private sector was basically a 'best guess' estimate.

In 1996, the then NSW Minister for Health reported that the running costs of the Hospital were between \$4.5 million to \$6.5 million more than running a public hospital of the same size providing the same services.

The privatisation strategy transferred significant public funds from the public sector into the private sector. In 2004, the NSW government decided to buy back the Port Macquarie Base Hospital at a cost of \$35 million.

Sources: Collyer, F. (1997) 'Privatisation and the Public Purse: The Port Macquarie Base Hospital, *Just Policy*, No. 10; NSW Auditor General (1996), *NSW Auditor General's Report*, vol.1.; Radio National (1996) *Background Briefing*, 20 October

cited in Senate Community Affairs References Committee (2000).

Modbury Hospital, South Australia

Modbury Hospital in South Australia was a 255 bed public hospital built in the 1970's and run by the government. The Modbury hospital board asked for and sought expressions of interest for a 65 bed co-located private hospital in 1993. In 1995 the health minister not only awarded the co-location but also contracted the running of the public hospital to Healthscope for 10 years, renewable for 20 years.

By 1997, Healthscope had raised a number of concerns with the contract including continued losses. It was alleged that the contract price was insufficient to enable it to support the long term completion of the contract.

Coopers and Lybrand were engaged to report on matters concerning the contract and identified a number of key deficiencies in the contract management process and in the original management agreement.

In 1997 the contract was substantially amended and re-executed after the Government decided that it would be acting against the public interest in not proceeding to amend the contract. It was estimated that the renegotiated contract reversed losses of around \$2 million in 1996-97.

The SA Auditor General, in its audit of the Hospital contract in 1997, reported that difficulties had arisen between 1995 and 1997 between the Government and Healthscope over a number of ambiguities in the original management agreement.

The Auditor General concluded the Modbury Hospital contract provided an example of some of the difficulties associated with contracting out and that the Government had a non-delegable duty of care in matters of the provision of public health.

In 2007, Healthscope handed back management of the Modbury Hospital to the South Australian government more than 10 years after it was privatised.

Source: South Australia Auditor General (1998) *Report on Summary of Confidential Government Contract under s41A of the Public Finance and Audit Act 1987 Modbury Hospital: Audit Commentary and Recommendations, 1997-98*; Submission No.65, p.13 (ANF (SA)); Submission No.16, p.12 (Queensland Nurses Union), Committee Hansard, 23.2.00, p.183

cited in Senate Community Affairs References Committee (2000).

Latrobe Regional Hospital

Latrobe Regional Hospital was opened after the closure of public hospitals at Moe and Taralgon. Australian Hospital Care (Latrobe) Pty Ltd, a wholly owned subsidiary of Australian Hospital Care Pty Ltd, was contracted by the Department of Human Services to build, own and operate the new hospital, with exclusive rights to provide public hospital services in the region for a period of 20 years.

The contract was not made public. In 1999, the Victorian Civil and Administrative Appeals Tribunal ordered that the then Government release the contract. The Government appealed to the Supreme Court.

In October 2000, Australian Hospital Care announced that the Latrobe Hospital would be transferred to the Victorian Government on 31 October.

Australian Hospital Care had reported a loss of \$6.2 million in 1999 for the hospital and was forecast to lose \$2.7 million in the current year (until the transfer to the Government). The company had written off its \$17 million investment in the hospital.

The then Victorian Minister for Health stated that 'the losses incurred by Australian Hospital Care meant it could no longer guarantee the hospital's standard of care'.

Under the transfer arrangement, Australian Hospital Care was released from its contract in return for discontinuing legal action against the Government, selling its \$12.6 million stake in the hospital building for \$6.6 million and giving the Government a cash payment of about \$1 million.

Source: Rollings, A. (2000) 'La Trobe hospital returns to public control', *The Age*, 24 October; *Victorian Legislative Assembly, Debates*, 14.5.99, p.1111.

cited in Senate Community Affairs References Committee (2000).

Not only Modbury Hospital, Port Macquarie Base Hospital and La Trobe Regional Hospital, but also Queensland's St Vincent's Hospital at Robina all had to be bought back by state governments at taxpayers' expense, following mismanagement by private operators.

A West Australian (WA) parliamentary committee confirmed the Fiona Stanley Hospital in Perth, operated by SERCO, was \$330 million over budget. The WA state government withdrew SERCO from providing clinical services and these services reverted back to the WA Department of Health.

Despite its initial announcements, the Newman government reversed its decision to privatise the Sunshine Coast University Hospital after admitting the private sector could not match the public service on cost. The Newman government eventually withdrew its plans to privatise a number of public hospitals following a major advertising and community based campaign by the QNU which pointed out the financial and clinical risks involved – risks confirmed by KPMG reviews of the Queensland Government's plans (KPMG, 2013).

All of these examples demonstrate the extreme costs to the communities and tax payers when governments proceed with privatisation of health facilities despite widespread opposition.

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Ways to improve the implementation of choice in end-of-life care

The Commission is seeking information on ways to improve the implementation choice in end-of-life care. For many years, the QNU and its federal peak body, the Australian Nursing and Midwifery Association have been campaigning for greater funding to address the needs of older Australians.

The QNU supports improvements to funding arrangements that could contribute to the more end-of-life services, however, while we recognise this need, we point out that end-of-life is just one small part of the whole aged care sector which itself is in desperate need of overhauling.

There is increasing evidence that residential aged care in Australia is facing issues arising from reduced staffing levels, fewer registered and enrolled nursing staff, and increased resident acuity (Allard 2014; Chenoweth et al., 2014; Gao et al., 2014; Henderson et al., 2016a; King et al., 2013). Recent budget decisions along with the implementation of consumer-directed care from 2017 onwards are likely to further reduce the funds available under the Aged Care Funding Instrument (Ansell, Cox & Cartwright, 2016).

A recent Australian study on the meeting the care needs of residents in aged care facilities found:

1. Staffing levels in residential aged care facilities (RACFs) are currently not sufficient to ensure safe, quality aged care;
2. Current skills mix does not address the increasing complexity and acuity of residents in residential aged care and leads to missed care. Increasing acuity has occurred alongside changes in skills mix that have resulted in fewer RNs and a higher proportion of PCWs. This occurs within a context of cost savings by employing less qualified and therefore less costly staff (Willis et al., 2016, p. 101).

Six typical residential care profiles used in the study showed that the time taken to complete all nursing and personal care interventions ranged from 2.5 to 5.0 hours per day with focus group participants suggesting that an additional 30 minutes be added to all profiles.

Drawing upon data from the Bentley survey of residential aged care, Allard (2016) noted that in 2015, residents received 39.8 hours of direct care/fortnight in Australian RACFs which averaged up to 2.86 hours/resident per day, raising serious concerns about safe staffing levels (Willis et al., 2016, p. 99).

End-of-life care is part of the continuum of aged care where nursing plays a vital role. This important contribution is being undermined through the use of unregulated workers rather than nursing professionals in the provision of home and residential aged care. Advanced care plans should be drawn up with the assistance of a registered health practitioner who can advise on potential end of life options, a legal professional, the individual and the family.

Again, we seek proper funding of the aged care sector and the engagement of properly qualified nurses to carry out nursing work.

Quality of care – quality of life

The *Aged Care Act 1997 (Cth)* and its subordinate Principles legislation all fail to address the practical differences between personal care and nursing care, despite these two types of care being by far the most common provided to home and residential aged care recipients.

The expansion of home care packages and an 'ageing in place' philosophy in recent years has resulted in recipients being cared for in their own homes for longer periods, and an increasing dependency and more complex health care needs.

Where in former years much of the home care could be provided by unregulated carers, this situation has changed dramatically with many recipients now requiring nursing care of an increasing complexity. However, we find that RNs and ENs employed by aged care approved providers to deliver care in the home are few and far between.

The current situation, in our view, is at least in part a product of the suite of legislation's failure to differentiate between nursing care and personal care and prescribe that nursing care must be provided or supervised and evaluated by a RN.

This failure has allowed providers to deliver aged care in the home without being required to engage RNs and ENs resulting in a lowering of the quality of care that could be provided and the shifting of healthcare costs to the state through unnecessary referrals or admissions to public sector health services.

Nursing

Nursing takes a holistic rather than task oriented approach to health care and includes the physical, mental and emotional care of the person. 'Choice in home care' packages establish the framework for non-regulated carers to perform tasks that may fall within the nursing scope of practice and which must be undertaken by a qualified, regulated professional. There needs to be a clear understanding of who is responsible for co-ordinating and monitoring care plans.

Not all persons with a direct or implied obligation or responsibility for caring for individuals or groups are necessarily engaged in nursing. For example care by an unpaid carer or relative in the home environment is not considered to be nursing.

Nursing practice is undertaken by RNs, ENs and Nurse Practitioners (NPs) who are regulated to practise as nurses. AINs are delegated aspects of nursing care by RNs and provide that care under the direct or indirect supervision of RNs. Current nursing regulation also requires that the outcomes of any nursing care provided by employed AINs or carers, whether in the home or the residential setting, must be evaluated by a RN.

Individuals practising nursing should undertake relevant education and possess the required qualifications for registration. RNs, midwives and ENs comply with the Nursing and Midwifery Board of Australia (NMBA) National Standards for Practice.

Whilst AINs are accountable to a National Code of Conduct for Healthcare Workers, the qualifications they may undertake are not subject to NMBA scrutiny or approval, hence there is no accreditation of an AIN's educational preparation in the nursing context.

This lack of standardisation is exacerbated by the absence of NMBA-approved Standards for Practice for AINs that would provide them with clear accountability and a concise, practical framework for the appropriate delegation of nursing care in various contexts. This is why the QNU and the ANMF have consistently campaigned for the regulation, by the NMBA, of any healthcare workers who provide care under the supervision of a RN.

The provision of personal care to individuals enables them to live independently and facilitates their integration and participation in the community. Decisions about whether personal care should be provided by a nurse or another level of worker should only be made by a RN. A RN assesses the characteristics of the person requiring care, the activities to be performed, and the competence, education and authority for practice of the person providing the care.

It is important the consumer has a role in directing the care provided, is aware of the different types of workers who will be providing their personal care and is empowered in the knowledge that any nursing care they receive must be delivered or supervised and evaluated by a RN.

It cannot be assumed that a person receiving a health service in their own home is mentally competent. In fact, an ever increasing number of aged care home packages are for persons with dementia or cognitive decline. If the care recipient is not mentally competent they will require the assistance of a registered health practitioner to assess and decide on the level and type of care necessary.

As health care workers have a range of different qualifications and experience, consumers need education and support in making decisions related to the type of care they receive and who delivers it. End-of-life matters fall into this category.

The QNU opposes the erosion of aged care nursing positions and/or services in any setting by the employment of other staff categories (however titled) to manage or provide nursing care.

Strengthening Accountability for Public Funding in Aged Care

The QNU advocates more rigorous transparency and accountability for public funding provided to all health and aged care services through improved public reporting including nursing and midwifery staffing numbers, skill mix and quality outcomes.

Despite several years of campaigning for greater regulation in the aged care sector and equitable payment for nurses, nurses working in this sector continue to receive significantly

less wages than their colleagues in the public and private sectors.⁴ This in turn often results in an inadequate skills mix⁵ because of the shortage of RNs in this sector. Any plan to further deregulate the aged care sector and increase competition will put profits before the interests of residents. It reflects the perceived needs of business, not the needs of residents.

The QNU recommends greater regulation and accountability, not less, in key areas of aged care including:

- requiring residential aged care providers to employ adequate nursing staff based on a methodology that incorporates the time taken for both direct and indirect nursing, personal care tasks, assessment of residents, the level of care required by residents and a skills mix of RN 30%, EN 20% and PCW/AIN 50% as the minimum (Willis et al., 2016);
- improving transparency and accountability in government funding and consumer payments; and
- licensing of all workers providing nursing in aged care, including AINs/personal carers irrespective of the job title their employer might give them;
- securing a greater wages share for nurses employed in aged care, who, since the Howard Coalition Government's first round of deregulation in the late 1990s, now earn considerably less than their colleagues in the hospital sector.

Alternatives Models of funding public health service delivery

If Australia is to keep growing national income as the terms of trade decline it needs a significant increase in both infrastructure and operational capital investment. The QNU believes there are alternatives other than privatisation and sale of assets to fund new infrastructure including a fairer taxation system where large business interests contribute more reasonably to Australia's economy. We suggest effective corporate tax avoidance measures and the introduction of a financial transactions tax could fund new infrastructure rather than selling off government-owned assets.

The financial transactions tax is a modest levy of up to 0.05% on the trading of specific financial instruments such as stocks, bonds, derivatives, futures, options and credit default swaps. It is sometimes referred to as the 'Robin Hood Tax'. Each time one of these

⁴ This is currently around \$200 per week calculated on the base rate (ANMF, 2016, p. 34).

⁵ This refers to the most appropriate mix of staff required to provide safe, quality care and is based on the ratio of RNs to other nursing staff.

financial products is traded, the levy applies. The tax targets the large profits made on risky, high-volume trading rather than the everyday transactions made by the general population.

We ask the Commission to look seriously into the adoption of this tax as a fairer means of financing infrastructure and investment in capital.

The QNU recommends:

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

Conclusion

The QNU is always willing to discuss genuine reform ideas. We are continually involved in negotiations for enterprise agreements and workplace initiatives aimed at improving the efficiency, productivity and efficacy of the health and aged care systems. These are core elements of competition policy that must not be compromised through poor funding or the belief that 'contestability' and 'user choice' will necessarily provide the platform for better outcomes.

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