



Queensland Nurses' Union

Review of Public and Private Hospitals

Submission to
the Productivity Commission

November 2009

Introduction

The Queensland Nurses' Union (QNU) welcomes the opportunity to provide a submission to the Productivity Commission in response to the Public and Private Hospitals Discussion Draft Paper (the draft). We recognise that the draft brings together and analyses a significant amount of information from both sectors that is not always compatible or indicative of overall performance. In this paper, we put forward some broad comments that the QNU considers relevant to the review and ask that the Commission reads our submission in conjunction with that of our federal counterpart, the Australian Nursing Federation (ANF).

About the QNU

The QNU is the principal health union operating in Queensland and is indeed the largest representative body of women in this state. It is registered in this state and in the federal jurisdiction as a transitionally registered association. In addition, the QNU operates as the state branch of the federally registered ANF.

The QNU covers all categories of workers that make up the nursing workforce in Queensland including registered nurses, midwives, enrolled nurses and assistants in nursing employed in the public sector or the private and not-for-profit health sectors¹. These, and other aged care workers are vital in providing the expert care that all Australians need. Our 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 QNU is party to over 200 enterprise agreements which cover a diverse range of health facilities and other non-health establishments that provide nursing services (eg schools, local councils, prisons and universities). We therefore have a clear and comprehensive understanding of the complexity of contemporary health service delivery as well as the diversity of employment opportunities such a system presents.

The QNU has a significant interest in the performance of public and private hospitals and the analysis of costs of performing clinically similar procedures. Nurses comprise the largest professional group in the health workforce. Due to the nature of their practice, nurses are very aware of the differences in patient profile between public and private hospitals. The inability to make a proper comparison between the two sectors was of course hampered by the differences in data collection and the delays in providing it. This means that any conclusions drawn from the comparison may be tenuous.

In the following section we comment on several aspects of the draft highlighting data collection, comparative costs, quality standards and workforce issues. Our comments relate mostly to the Queensland hospital system.

¹ Throughout this submission the terms 'nurse' and 'nursing' are inclusive of 'midwife' and 'midwifery' and all nursing designations such as 'nurse practitioner'.

Data collection across public and private hospitals.

As the draft consistently pointed out, there is a need for more effective, consistent and transparent methods of data collection across both sectors to meet public interest obligations. We believe that data from all health services should be accessible to a range of users in order to drive improvements to the overall health care system.

The purpose of comparable data is to ensure that there is a credible measure between like services within both sectors thus eliminating estimates or general assumptions. A comparison of data from the public and private hospitals should be measured by patient outcomes. At present, both parties have differing levels of public accountability that leaves some activities in the private sector undisclosed. Public hospitals are subject to open disclosure where they must make both sentinel and adverse event data available. Freedom of Information legislation supports open disclosure but this does not apply to the private sector. The private sector is only required to report sentinel events under the *Queensland Coroners Act 2003*. Therefore apart from these events there is no requirement for a private facility to disclose publically any information regarding a settlement with a patient relating to other matters such as an adverse event. Thus, there are limited means for organisations such as ours to address adverse outcomes that may result from inadequate staffing levels in this sector.

To some extent the private sector self regulates. The accreditation tool varies from organisation to organisation, however many accreditors are from the private sector. According to the Queensland licensing unit, each accreditor has a different approach in spite of the chosen tool including the same questions. Organisations require accreditation before they can negotiate with private health funds. This creates a pressing need to be successful in accreditation in the private sector.

Any requirement to provide data on a national basis should be consistent and able to be independently audited facility by facility. The reporting of unsafe or adverse events needs to occur on a reliable basis in both sectors. Our members in the private sector have claimed their reports on adverse events have been destroyed at the ward /unit level and that incentive bonuses paid to managers for meeting performance targets sustains this practice.

Comparative differences in costs

The draft notes that it was a major challenge to report comparative cost data and that the costs estimates should be treated as 'experimental'. Clearly the private for-profit sector has a different motive than the public sector and will operate according to a different set of principles. It is therefore unsurprising that a comparison of the two sectors reveals higher costs for nursing and other non medical wages, consumable etc and higher medical costs in the private sector. **As the** private sector provides services that will give the best return on investment, they will perform surgery in the most profitable areas. This leaves the community with limited meaningful choice in health services, particularly in rural areas and puts more pressure on the public sector.

There are also anomalies in the method of counting patients that may skew the national data. The true count of patients in most facilities is done at midnight. In some private facilities this means the count does not include day patients, yet care and nursing hours have been taken up by the admissions. From the draft, it seems that the day surgeries are funded on the number of separations as opposed to case mix.

The draft data does not include babies born at the facility as data relevant to cost, because it only includes the mother in the patient count unless a twin is born. This remains a hidden cost in both sectors. Again, this is an area of nursing and midwifery that the data does not recognise nor capture. There is an urgent need for standardised data sets and definitions to be established to facilitate meaningful comparisons between sectors.

Robust Quality Framework

The QNU believes that all sectors need a robust quality framework including nurse/midwifery sensitive indicators. The draft does not include data to demonstrate nurse or midwife sensitive input into health care outcomes. Nurses and midwives within the Queensland private sector appear to operate within a team approach led by a registered nurse or midwife while other members of the nursing team consist of enrolled nurses, assistants in nursing or personal carers who receive lower rates of pay than nurses. Without sufficient data to demonstrate the ratio of registered nurses to other nursing staff in each sector, it is difficult to determine how 'lean staffing costs' in the private sector provide quality outcomes. Recent research (Hoffman, Aitken & Duffield, 2009) indicates that where registered nurses provide continuous patient care, there are better outcomes for the patient.

A medical model of care in private hospitals may attract doctors to an organisation, but it is not an efficient use of a skilled workforce, nor is it conducive to the preceptorship and support of new employees including new graduates as they transition to skilled clinicians. We believe that further work must be done to establish nurse/midwife sensitive indicators that measure outcomes across all sectors.

Workforce issues

The draft refers to the nursing workforce in the private sector as "qualified", however it does not define the meaning of this term. The private sector employs unlicensed practitioners who do not hold formal qualifications, but we believe that these unlicensed practitioners have been included in this category in the draft. In Queensland, these staff and administrators are included in the nursing hours for the cost centre budget. As there is no transparency or indeed reliable data on the actual workforce profile in the private sector, there is no dependable evidence available to make comparisons. We seek clarification regarding whether the Commission is confident that the workforce data, especially the data quoted in the report relating to the nursing and midwifery workforce is robust and enables meaningful comparisons across sectors. Our experience with the annual Nursing and Midwifery workforce surveys in recent years is that the response rate for the survey is far from optimal and this makes meaningful data gathering and workforce analysis challenging.

The QNU believes that an independent audit process of staffing in each private facility would provide a more accurate indication of the alleged comparative efficiencies/leanness of the private sector with respect to staffing. This data must also be analysed in the context of a consistent framework across both public and private sectors for the reporting of health outcomes and adverse events as well as the service profile for each facility.

It is important to note that the agreed nursing and midwifery workload management tool utilised in Queensland Health (the Business Planning Framework (BPF)- Nursing Resources) matches demand with supply for nursing/ midwifery resources and incorporates a requirement for a

service profile to be built up for each clinical unit. The Commission may be interested in investigating this validated tool further as we believe that it provides an invaluable framework for workforce planning and the principle of the BPF can easily be applied across other clinical disciplines. Queensland Health and the QNU are undertaking further refinement of this important tool over the next few years so that it better takes into account acuity, skill mix and new models of care. The QNU would be happy to provide further information on this to the Commission upon request.

We note that the draft claimed that because private hospitals seem to operate with less staff than public hospitals, that this means there are excess or underutilised public hospital staff. This is of concern to the QNU because we believe there is still a critical shortage of nurses across the public and private hospitals and aged care. In our view it is impossible to make such an assertion on the numbers alone, without any reference to the significant differences that exist in relation to case mix and skill mix across sectors and the lack of meaningful data on health outcomes and adverse events in the private sector.

The significant migration to this state and its consequent demand on health services, especially in the south east corner, has accelerated the nursing shortage. The QNU estimates, based on Australian Bureau of Statistics (ABS) labour force and population growth data, that the shortage of nurses and midwives in Queensland will be around 14,000 by 2014 (ABS Cat No. 3222.0). In the public sector, Queensland Health's conservative shortage estimates are based only on maintaining the current service status and fail to take into account significant predicted retirements from the profession, backfill requirements for leave and training, as well as increases in services – such as new beds coming online – which all have a direct impact on the number of additional nurses required.

It is important that any review of both public and private hospitals addresses workforce issues, particularly in light of the ageing population, and the ageing of the nursing profession. The average nurse is now aged 43.7 years (Australian Institute of Health and Welfare, 2009) and this is increasing. The role of nursing in maintaining the health of the Australian population is vital. The QNU believes that we should also be looking towards ways in which we recognize and promote the unique role of nursing as a health profession through a range of strategies.

The QNU's *Nurses. For you. For life* campaign aims to address the nursing shortage in Queensland. Our campaign seeks more nurses, safe workloads and appropriate skill mix, supportive and safe workplaces, quality and accountability, equity in pay and health standards, education, patient advocacy, and innovative and sustainable care.

Aged care

Aged care is a critical issue facing our nation. Currently, there are some 2.8 million Australians – about 13 per cent of the population – aged 65 and over. Estimates indicate that this number will triple in 40 years (Commonwealth of Australia, Department of Ageing, 2008). The rising dependency on aged care that this forecast suggests coincides with a national shortage of nurses, particularly in the aged care sector where there has been a significant decrease in the number of licensed nurses in the last ten years. Lack of wage parity with other areas of nursing, onerous workloads, and an inadequate mix of nursing staff necessary to meet the increasingly complex needs of residents in aged care facilities, exacerbate the recruitment and retention problems in this sector.

Although the draft compares the private and public hospitals, this continues to exclude aged care from mainstream health care discussions. The QNU views health and aged care as one sector because of the ever increasing acuity levels and complex care needs of residents in aged care facilities and because of the continuum of care that should exist across all sectors in a patient/resident centered system. For some time, the QNU has sought implementation of mechanisms to monitor how aged care providers spend allocated funding. Funding in residential aged care should include a transparent and accountable allocation of the health and aged care component with a separate allocation of funds for accommodation and other services accounted for independently. The QNU therefore believes that any measures to improve data collection, quality indicators and cost assessments in the public and private hospital system should include the aged care sector to ensure consistent standards across reporting and care.

Conclusion

While we welcome the information in the draft, the QNU believes that the public and private sectors can complement each other if particular services are fixed to a facility. Currently, changes in private sector services are driven by commercial imperatives and demand rather than community need for services. Without giving due consideration to this issue, the emergence of a dual or “two tiered” system where some communities or socioeconomic groups have access to the full range of health services and others do not will continue.

References

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- Commonwealth of Australia, Department of Ageing (2008) *Report on the Operation of the Aged Care Act 1997*.
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