



Australian  
Nursing &  
Midwifery  
Federation

Submission to

Productivity Commission Inquiry

*Introducing Competition and Informed User Choice into Human  
Services*

*Stage 2: Human Services reform*

23 February 2017

Lee Thomas  
Federal Secretary

Annie Butler  
Assistant Federal Secretary

Australian Nursing & Midwifery Federation  
PO Box 4239 Kingston ACT 2604  
T: 02 6232 6533  
F: 02 6232 6610  
E: [anmfcanberra@anmf.org.au](mailto:anmfcanberra@anmf.org.au)  
W: [www.anmf.org.au](http://www.anmf.org.au)

## INTRODUCTION

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with branches in each state and territory of Australia. The core business of the ANMF is the professional, political and industrial representation of our members and the professions of nursing and midwifery.

As members of the union, the ANMF now represents over 259,000 nurses, midwives and assistants in nursing nationally. They are employed in a wide range of enterprises in urban, rural and remote locations, in the public, private and aged care sectors including nursing homes, hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, and off-shore territories and industries.

The ANMF appreciates the opportunity to provide input into the Productivity Commission's (PC's) current consultations on the second stage of the Human Services Inquiry, *Reforms to Human Services*.

The ANMF's submission provides general answers to the PC's requests for information with a specific focus on public hospitals and end-of-life care. The submission builds on the ANMF's submission to stage one of the Inquiry, *Identifying sectors for reform*, and includes specific examples of how efficiencies can be achieved through better utilisation of the nursing and midwifery workforce.

## BACKGROUND

The members of the Australian Nursing and Midwifery Federation are committed to the provision of health as a public good with shared benefits and shared responsibilities. We consider that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact.

Though the provision of quality health services is frequently regarded as a burden, Government investment in health is in effect a growth and infrastructure investment that will pay dividends in the development of social capital and increased productivity for generations.

We are committed to publicly funded universal health insurance, i.e. Medicare, as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

We believe the Australian Government must take responsibility for ensuring that overall spending on healthcare remains affordable and that policy settings contain inflation. The scale and unpredictability of health costs means that insurance, be it public or private, is inevitably a major feature of the sector. The effect of a strong, high quality, comprehensive public insurer in competition with private providers is to exert downward pressure on prices.

*Private insurance is a high-cost and inequitable mechanism to achieve what the tax system and a single insurer can do far better. Its administrative overheads are high, and it lacks the incentives or capacity to control moral hazard and to contain health care costs.<sup>1</sup>*

While acknowledging and respecting the need for an effective private health system, the ANMF does not support the current public subsidy of the private health system. The public contribution is too great and does not provide reasonable return for all taxpayers and the wider community, in either health or economic terms.

The ANMF considers that Government has a key role in both the provision and management of health services, including public hospitals and end-of-life care and in regulation of the health and aged care sectors, including regulation of private health providers and the private health insurance industry. The ANMF considers that current regulatory structures need to be amended to ensure efficient and equitable delivery of good health outcomes in all sectors, particularly the private and aged care sectors.

## INTRODUCING COMPETITION

The ANMF agrees with the PC's comment that *competition and contestability are not ends in themselves, and should only be introduced where they are likely to lead to more effective service provision*, which means that the introduction of competition and contestability must lead to increased quality in care not just a reduction in costs.

This is particularly pertinent with regard to health services. The healthcare sector cannot be viewed as a traditional marketplace. The competitive levers, which are applied in normal markets, do not always translate to health 'markets'. The introduction of some competitive measures can be useful, e.g. removing the anti-competitive behaviour and restrictive practices, which prohibit access to the MBS for a range of health professionals, could lead to more efficient, better quality care. Other measures, however, could lead to much greater inefficiencies without any improvements in quality of care.

One such example is privatisation. This submission supports the comments and evidence provided by the Queensland Nurses' Union (ANMF Queensland Branch) in its submission to the Inquiry<sup>2</sup> with regard to: the role of Government; the drivers/causes of privatisation in Australia; public hospital funding; privatisation in health care and the case studies which demonstrate the inadequacies of privatisation of public hospitals.

While we note that the PC is not recommending privatisation of public hospitals at this stage, we must emphasise that the ANMF rejects the orthodoxy that privately delivered services and increased consumer choice will be more efficient than publicly provided services. This is particularly so in the healthcare sector where it is well understood that market mechanisms do not drive quality and efficiency.

---

<sup>1</sup> Ian McAuley, July 2016 Private health insurance and public policy, Centre for Policy Development, <https://cpd.org.au/2016/07/ian-mcauley-private-health-insurance-and-public-policy/>, accessed 17/02/2017.

<sup>2</sup> Queensland Nurses' Union, 2017, Submission to the Productivity Commission, Reforms to human services, pp. 4-15.

Competition must not be an end in itself but a means to achieve improved performance. Experience in Australia, the US and the UK suggest that competitive markets in healthcare are often imperfect—the effects of information asymmetry, natural monopoly, vertical service integration, service co-dependencies, costs of market entry, and so on can make it difficult to realise the benefits of competition and can instead produce a range of adverse and unintended consequences such as excessive complexity, patient selection by providers, overtreatment, and lower clinical quality.<sup>3</sup>

A patient rarely has the knowledge and expertise to make an informed judgment nor is shopping around for better quality or price a realistic option. The leading types of ill health in Australia are cancer (16%), musculoskeletal disorders (15%), cardiovascular diseases (14%) and mental and behavioural disorders (13%).<sup>4</sup> The idea that a typical patient receiving care for any of these is in a position to bargain effectively with multiple providers, appraise quality and reduce demand in response to price rises is nonsense.

There are very recent Australian examples of how the public/private model of privatisation has failed the twin objectives of value for money and performance. The most recent review of cancer outpatient treatment from the NSW Bureau of Health Information demonstrates that cancer patients receiving outpatient treatment do not consider they are getting value from private facilities. They rate the privately run Chris O'Brien Lifehouse, the most celebrated and best funded cancer hospital in NSW<sup>5</sup>, as underperforming compared with public counterparts against a range of important clinical quality measures.<sup>6</sup>

Lifehouse is a private facility that is contracted by Local Health Districts to provide care for public patients. While the physical environment and comfort rated well, many important clinical and quality measures underperformed.<sup>16</sup> The exact reasons for this underperformance are not clear, but it is clear from the data that substantial investment has been made to enhance the appeal of the built environment. Whether or not similar emphasis has been placed on quality of care is not so clear, and the data indicates significant failings.

When we consider accommodating patient satisfaction, it is crucial that we differentiate between making patients happy and making them well. Patient satisfaction is important but this subjective measure must not be allowed to distract from health outcomes and objectives.

In our view Lifehouse provides a window into what overemphasis on competition, contestability and user choice does in healthcare: patients cannot be expected to exercise an informed assessment of the quality of the service or clinical outcomes, but may be impressed by modern design and a sleek built environment. All the other services on which data was collected are public, operating without the pressure to attract patients or deliver an operating surplus, and they are delivering superior care at a more efficient price.

---

<sup>3</sup> Kieran Walshe, BMJ 2011;342:d2038, <http://www.bmj.com/content/342/bmj.d2038>

<sup>4</sup> AIHW, Australia's Health 2014, <http://www.aihw.gov.au/australias-health/2014/ill-health/>

<sup>5</sup> Alexander, H. 20 July 2016 Chris O'Brien Lifehouse gets poor patient ratings for symptoms, participation and positivity, Sydney Morning Herald, <http://www.smh.com.au/national/health/chris-obrien-lifehouse-gets-poor-patient-ratings-for-symptoms-participation-and-positivity-20160719-gq94u1.html>

<sup>6</sup> Bureau of Health Information. *Patient Perspectives – How do outpatient cancer clinics perform?*

*Experiences and outcomes of care, February and March 2015.* Sydney (NSW); BHI;

2016. [http://www.bhi.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0004/320836/patient-survey-outpatient-cancer-clinics-2016.pdf](http://www.bhi.nsw.gov.au/__data/assets/pdf_file/0004/320836/patient-survey-outpatient-cancer-clinics-2016.pdf)

## PUBLIC HOSPITALS

### Competition between clinicians or hospitals

As advised above, introducing competition between clinicians and hospitals should be approached with significant caution. Rather than introduce traditional competitive measures, policy and regulatory controls, which control unnecessarily costly care, encourage avoidance of ineffective care and reduce waste, should be developed and introduced.

The ANMF directs the PC to the following reports, examples of which are briefly outlined below, for evidence on how to improve efficiency and effectiveness in public hospitals with regard to these factors.

#### ***Grattan Institute Report - Controlling costly care: a billion-dollar hospital opportunity<sup>7</sup>***

*The gulf between treatments in high and low-cost hospitals in Australia is vast, with no good reason for such variation. In New South Wales, for example, the difference in the cost of a common gall bladder treatment between the highest and lowest-cost hospitals is more than \$4,000, and the difference in the cost of a hip replacement more than \$16,000. In many states the gap between the most and least expensive hospitals is more than \$1,500 for every admission — and in some states it is much greater — even when all legitimate funding differences among hospitals that we can measure are taken into account.*

*This money is not being used to provide better care – it is simply being spent inefficiently and could be used for much better ends. To achieve the savings, the report urges state governments to make three reforms.*

*They should pay hospitals for treatments on the basis of an average price once all avoidable costs we can measure have been removed.*

*Second, they should make data available to hospitals so they can compare themselves to their peers and see where they can cut costs.*

*Third, governments need to be tougher and hold hospital boards to account when they fail to control costs.*

*Hospital spending is the fastest growing area of government spending, and is projected to increase with new technologies and an ageing population. We have to keep health care affordable and the health budget under control. Rooting out inefficiencies in public hospital systems is a good place to start.*

---

<sup>7</sup> Duckett, S.J., Breadon, P., Weidmann, B. and Nicola, I., 2014, *Controlling costly care: a billion dollar hospital opportunity*, Grattan Institute, Melbourne. Available online at: <https://grattan.edu.au/wp-content/uploads/2014/03/806-costly-care.pdf>

**Australian Commission on Safety and Quality in Health Care Report – Exploring Healthcare variation in Australia: Analyses resulting from an OECD study<sup>8</sup>**

*Unwarranted variation raises questions about quality, equity and efficiency in health care. For instance, it may mean some people have less access to health care compared with others. It may suggest that factors other than patients' needs or preferences are driving treatment decisions. It may indicate that some people are having unnecessary and potentially harmful tests or treatments, while others are missing out on necessary interventions.*

*Unwarranted variation may also mean that scarce health resources are not being put to best use. As countries face increasing pressure on health budgets, there is growing interest in reducing unwarranted variation in order to improve equity of access to appropriate services, the health outcomes of populations, and the value derived from investment in health care.*

*Determining if variation is indeed unwarranted can be challenging, particularly without routine information on patient needs and preferences. Information on the outcomes of treatment is also critical.*

**Grattan Institute Report – Questionable care: avoiding ineffective treatment<sup>9</sup>**

*This report identifies five treatments that should not be given to certain types of patients. Yet this happened to nearly 6000 people – or 16 people a day – in 2010-11.*

*These treatments – which include treating osteoarthritis of the knee with an arthroscope, filling a backbone with cement to treat fractures and putting patients in a pressurised oxygen chamber when it will not improve their condition – can cause harm. Some patients who had the treatments developed infections during their hospital stay or could have avoided the stress, cost, inconvenience and risk of a hospital stay altogether.*

*These treatments happen in only a minority of hospitals, but some of those hospitals provide them at 10 or 20 times the average rate, at great cost to patients and the community. Australia needs a system to let these outlier hospitals know where they stand so that they can improve their care. More thorough use of data that governments already possess could identify many more treatments that should be performed rarely or never on many patients.*

*This report explains how and why some patients get ineffective care and what governments should do to ensure that far fewer people get the wrong treatment.*

**Consumer choice related to models of care and preferred clinicians**

The ANMF considers that patients and consumers should have more choice in the public system in selecting both the type of clinician and model of care used to treat and/or manage their injuries, illnesses and conditions. Currently there are few options and little choice available to the majority of Australians as many health professionals are not supported by government to offer models of care which may be more appropriate for many consumers across a range of conditions. This is despite a growing body of evidence demonstrating the effectiveness, both in terms of reducing cost and improving outcomes, of alternative models of care.

<sup>8</sup> Australian Commission on Safety and Quality in Health Care Report – Exploring Healthcare variation in Australia: Analyses resulting from an OECD study. Sydney: ACSQHC, 2014.

<sup>9</sup> Duckett, S., Breadon, P, Romanes, D. Fennessy, P., Nolan, J. 2015, *Questionable care: Stopping ineffective treatments*, Grattan Institute. Available online at: <https://grattan.edu.au/wp-content/uploads/2015/08/828-Questionable-Care3.pdf>

Australia has a highly qualified and skilled nursing and midwifery workforce which is largely under-utilised. Nurses are well placed to undertake individualised care planning, as they have the capacity to assess, plan, implement and evaluate the unique requirements of patients in primary care while working in collaboration with the multidisciplinary team using referral pathways.

However, nurses and midwives are currently denied opportunities to realise their full potential and provide maximum contribution to the health system. Opening these opportunities and undertaking appropriate workforce reform, particularly in primary care and transition care, will provide better service to more people much more cost effectively. This would involve, in particular, much better use of nurse practitioners and a significant expansion of nurse-led and midwife-led clinics.

Outlined below are several case studies from Australia and overseas, which demonstrate these effects.

## NURSE/MIDWIFE-LED CLINICS

The establishment of nurse/midwife-led clinics is expanding in Australia, however, it is occurring slowly and tends to be indicated and implemented where there are service gaps due to high demand and/or workforce shortages rather than as part of a broader health care strategy. This is despite a growing volume of research indicating that nurse/midwife-led clinics have been shown to improve patients' outcomes and facilitate timely access to specialist services.

The following benefits have been demonstrated:

**For patients:** patients have a shorter wait for their specialist outpatients appointments and have high levels of satisfaction with the care they receive in nurse-led clinics. This model of care can also facilitate earlier discharge of patients back to General Practice services.

**For nursing staff:** Increased job satisfaction potentially resulting in increased recruitment and retention due to advanced role.

**For medical staff:** Medical staff are able to concentrate on more complex patients.

**For the hospital:** Nurse-led clinics increase the efficiency of clinics, are cost effective and reduce waiting time in outpatients.

International research, from the UK, Europe and North America where nurse-led clinics are more widely used, has demonstrated not only the effectiveness of nurse-led clinics in terms of clinical outcomes but also in terms of reducing costs.

### **CASE STUDY – Nurse-led rheumatology clinic versus rheumatologist-led clinic**

*In Europe, one randomised controlled study compared the costs of rheumatology care between a nurse-led rheumatology clinic (NLC), based on person-centred care (PCC), versus a rheumatologist-led clinic (RLC), in monitoring of patients with Chronic Inflammatory Arthritis (CIA) undergoing biological therapy.*

*The researchers concluded that patients with CIA and low disease activity or in remission undergoing biological therapy can be monitored with a reduced resource use and at a lower annual cost by an NLC, based on PCC with no difference in clinical outcomes.*

*The results showed the total annual rheumatology care costs including fixed monitoring, variable monitoring, rehabilitation, specialist consultations, radiography, and pharmacological therapy, generated €14107.7 per patient in the NLC compared with €16274.9 in the RCL ( $p = 0.004$ ), giving a €2167.2 (13 %) lower annual cost for the NLC and freeing resources.*

The savings above were identified in a single clinic, related to just 97 patients.<sup>10</sup> It is very clear that wider use of nurse-led clinics in Australia would lead to significant cost savings within the health system.

#### **CASE STUDY - The Buurtzorg model**

*Buurtzorg Nederland was founded in 2006 by Jos de Blok and a small team of professional nurses who were dissatisfied with the delivery of health care by traditional home care organizations in the Netherlands. Together they decided to create a new model of patient-centred care focused on facilitating and maintaining independence and autonomy for the individual for as long as possible.*

*The model supports an empowered nurse-led team approach, as well as an empowered patient. The model encourages patients to participate with their Buurtzorg nurse in finding solutions to their home care needs, many of which can be found right in the community. What started as a team of 4 nurses in 2006, has grown to nearly 8,000 nurses in 2014, with teams in the Netherlands, Sweden, Japan and now, the United States. A 2010 Ernst & Young report documented savings of roughly 40 percent to the Dutch health care system, and a 2012 KPMG case study found:*

*“Essentially, the program empowers nurses (rather than nursing assistants or cleaners) to deliver all the care that patients need. And while this has meant higher costs per hour, the result has been fewer hours in total. Indeed, by changing the model of care, Buurtzorg has accomplished a 50 percent reduction in hours of care, improved quality of care and raised work satisfaction for their employees.”*

#### **The Buurtzorg Approach**

*Buurtzorg’s highly qualified and well-trained licensed community nurse teams create positive and proactive solutions to provide compassionate, effective, holistic, quality care. This personalized attention and team approach allows individuals to stay in their homes and communities for as long as possible, avoiding more costly institutional care. Working closely with each individual patient, family members, primary care provider, and — as needed — other health care and community professionals, the Buurtzorg nurse works to design and implement the most appropriate and effective care plan based on an individual’s needs. Buurtzorg’s community-based nurse-led teams integrate the latest research and innovations with practical common sense, creating a simple design of community-based, patient-centred health care delivery.*

#### **What Distinguishes Buurtzorg from Other Home Care Organizations?**

*The team approach allows for the best solutions to promote independence and the quality of life, and allows nurses the autonomy to practice to their highest level of training. All Buurtzorg nurses are responsible for promoting and providing outstanding care. They focus not only on current needs, but also on preventing future problems. Nurses are supported by a simple and streamlined organization with modern IT technology to facilitate “real time” information that is directly connected to the care process and reduces administrative overhead.<sup>11</sup>*

Nurse-led models of care, such as the Buurtzorg model, could and should be used throughout Australia.

<sup>10</sup> Larsson, I., Fridlund, B., Arvidsson, B., Teleman, A., Svedberg, P. and Bergman, S. (2015) Nurse-led rheumatology clinic versus rheumatologist-led clinic in monitoring of patients with chronic inflammatory arthritis undergoing biological therapy: a cost comparison study in a randomised controlled trial, *BMC Musculoskeletal Disorders*. Available online at: <http://bmcmusculoskeletdisord.biomedcentral.com/articles/10.1186/s12891-015-0817-6>

<sup>11</sup> Full information about the model is available at: <http://www.buurtzorgusa.org/>



## NURSE PRACTITIONERS

Australia has a highly qualified and skilled health workforce which is dramatically under-utilised, the most critical example of this relates to nurse practitioners (NP). The NP role is the most advanced clinical nursing role in Australia, with additional responsibilities for patient assessment, diagnosis and management, referral, medications prescribing, and the ordering and interpretation of diagnostic investigations.

However, despite this capacity, structural and other barriers, such as very limited access to the MBS and inadequate funding arrangements, prohibit many NPs from working to their full capacity and broader use of the role generally.

These barriers not only waste opportunities for better health outcomes but also contribute to increases in health costs because of unnecessary duplication.

For example, in some situations when a NP identifies the need for diagnostic imaging, a pathology test, or referral to an allied health professional, the provision of care is impeded and delayed as NPs are required to direct patients to an additional GP visit or spend patient-facing time undertaking administrative functions to contact GPs and request an order. If the NP can find no other alternative they may need to resort to sending the patient to the ED further contributing to overcrowding and access block.

This results in:

- the precipitation of an otherwise avoidable MBS consultation item;
- delays in time to diagnosis and management which may lead to avoidable health complications for the patient;
- an avoidable administrative burden for NPs reducing their productivity; and
- a reduction in the time available for direct patient care.

This duplication occurs while opportunities for significant cost savings go unrealised. The following case studies present a small sample of the effectiveness of NPs. To realise the full benefits of NPs for the Australian health system, the barriers to their employment must be removed. The number of NPs in Australia needs to be increased ten-fold.

**CASE STUDY - An Evidence Check review brokered by the Sax Institute September 2009<sup>12</sup>**  
***Hospital nurse practitioners – models, roles and scope of practice: a rapid review***

*The research strongly supported the direction for NP utilisation within the area of critical care, anaesthetics, clinical procedures, minor surgery, and outpatient services.*

- *No appreciable difference was found between NPs and doctors in patient health outcomes. Patient satisfaction scores, in the majority of studies, were higher for NP care. Adherence to practice guidelines and appropriate medical record documentation was more reliable by NP than medical staff*
- *Evidence of a positive economic impact by NP models, compared with doctors (routine care), was commonly demonstrated. Observed cost savings flowed from shorter hospital length of stay, reduced investigations and interventions, and reduced patient complication and (re)admission rates*

---

<sup>12</sup> Adams E, Schofield D. Hospital nurse practitioners – models, roles and scope of practice: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au), 2009. Available online at: <https://www.saxinstitute.org.au/wp-content/uploads/Workforce-productivity-nurse-practitioner-report1.pdf>

**CASE STUDY – An aged care NP working in metropolitan Sydney.**

*The NP is employed full time Monday to Friday, with an aged care provider across 4 sites with 750 beds. The NP contributes to a specific program called RUTH (Reducing unplanned transfers to hospital).*

*In the past 12 months, the NP has provided direct care that has prevented 55 hospital transfers. This does not include all of the situations where hospital transfer was indirectly prevented due to prophylaxis or advanced care planning, just the situations where at the point of crisis hospital transfer was called for and avoided.*

*In order to understand the cost benefit of the NP role in hospital avoidance several calculations must be made, including the costs of ambulance transfer, ED visit, investigations, pathology tests and the cost of a hospital bed.*

*Using conservative estimates of these costs averaged across the population of 55 aged care residents, and assuming that a transfer to hospital without admission would cost approximately \$2,000 and a transfer with admission (assuming the average length of stay for this population of 11 days) would cost approximately an extra \$6,000, savings can be calculated.*

*Based on the assumption that half the residents prevented from being transferred to hospital would have been admitted, that is 27 occasions of transfer and admission at \$8,000, the cost savings equate to \$216,000. Assuming the remaining 28 occasions of transfer required non-admitted care in ED at \$2,000 per occasion, the cost savings equate to \$56,000 leading to a total of \$272,000 in savings.*

*The NP's wage is approximately \$110,000 per annum with an additional earnings of \$30,000 in the same 12 month period from billable items under Medicare. Using these gross calculations the net savings equate \$132,000.*

*These are the savings created by one NP related to the 55 residents discussed. This does not take account of all the other activities performed by this NP in the normal course of her work.<sup>13</sup>*

**CASE STUDY - Development of a Nurse Practitioner led Carpal Tunnel Syndrome clinic<sup>14</sup>**

*This study aimed to examine how the role of nurse practitioner was implemented within a public hospital Department of Neurosurgery carpal tunnel syndrome clinic, a tertiary referral centre outpatient clinic. The study's findings inform practice describing the process of developing, implementing and the requirements to become a nurse practitioner role within a public hospital's Department of Neurosurgery within Australia. The study concludes that the introduction of a nurse practitioner role within the Department of Neurosurgery resulted in more timely access and cost effective care for patients referred to this specialised service.*

*As more NPs are endorsed throughout Australia further opportunities for innovative models of acute and ambulatory care will be delivered. The implementation of a NP led CTS clinic at Austin Health has shown to be a successful means of reducing clinic waiting times, whilst maximising available funding and possibly increasing patient satisfaction. An additional indirect benefit of the service included a 73% increase in surgical output for CTR and the associated income for the hospital. This study shows that NP led clinics are a valuable adjunct to the provision of medical care, and represent a feasible model to help ease the burden of busy hospital outpatient clinics.*

<sup>13</sup> Detailed analysis of the economic value of nurse practitioners in Australia can be found at:

[https://acnp.org.au/sites/default/files/docs/final\\_report\\_value\\_of\\_community\\_nps\\_1.pdf](https://acnp.org.au/sites/default/files/docs/final_report_value_of_community_nps_1.pdf)

<sup>14</sup> Full study available at: <http://www.ajan.com.au/Vol32/Issue3/5Scanlon.pdf>

## Rural and remote areas

In many rural and remote locations, there is only access to public health care services due to limited or no other providers. Many of the healthcare providers in these location are nurses and midwives. Therefore, nurse-led health care is an essential component of health care delivery in these areas.

Better choice could be provided to patients in regional or remote areas through different models of care especially nurse practitioner led models.

### **CASE STUDY - Evaluation of a pilot of nurse practitioner led, GP supported rural palliative care provision<sup>15</sup>**

#### *Background*

*Providing end of life care in rural areas is challenging. This study evaluated in a pilot whether nurse practitioner (NP)-led care, including clinical care plans negotiated with involved health professionals including the general practitioner(GP), ± patient and/or carer, through a single multidisciplinary case conference (SMCC), could influence patient and health system outcomes.*

#### **Methods**

*Setting – Australian rural district 50 kilometres from the nearest specialist palliative care service. Participants: Adults nearing the end of life from any cause, life expectancy several months. Intervention- NP led assessment, then SMCC as soon as possible after referral. A clinical care plan recorded management plans for current and anticipated problems and who was responsible for each action. Eligible patients had baseline, 1 and 3 month patient-reported assessment of function, quality of life, depression and carer stress, and a clinical record audit. Interviews with key service providers assessed the utility and feasibility of the service.*

#### **Results**

*Sixty-two patients were referred to the service, forty from the specialist service. Many patients required immediate treatment, prior to both the planned baseline assessment and the planned SMCC (therefore ineligible for enrolment). Only six patients were assessed per protocol, so we amended the protocol. There were 23 case conferences. Reasons for not conducting the case conference included the patient approaching death, or assessed as not having immediate problems. Pain (25 %) and depression (23 %) were the most common symptoms discussed in the case conferences. Ten new advance care plans were initiated, with most patients already having one. The NP or RN made 101 follow-up visits, 169 phone calls, and made 17 referrals to other health professionals. The NP prescribed 24 new medications and altered the dose in nine. There were 14 hospitalisations in the time frame of the project. Participants were satisfied with the service, but the service cost exceeded income from national health insurance alone.*

#### **Conclusions**

*NP-coordinated, GP supported care resulted in prompt initiation of treatment, good follow up, and a care plan where all professionals had named responsibilities. NP coordinated palliative care appears to enable more integrated care and may be effective in reducing hospitalisations.*

---

<sup>15</sup> Mitchell GK, Senior HE, Bibo MP, Makoni B, Young SN, Rosenberg JP and Yates P. (2016) Evaluation of a pilot of nurse practitioner led, GP supported rural palliative care provision, *BMC Palliative Care*, Available online at: <https://www.ncbi.nlm.nih.gov/pubmed/27829425>

In addition to the models outlined above, significant efficiencies can be achieved for public hospitals through implementation of nurse-to-patient and midwife-to-patient ratios.

## NURSE-TO-PATIENT RATIOS/MANDATED STAFFING

Nursing is fundamental in the delivery of safe, high quality, affordable health services. Mandating nurse-to-patient ratios guarantee a level of staffing, which will reduce costly adverse events, decrease unwarranted service variation and improve patient outcomes. Ratios provide patients with more direct nursing care while minimising the likelihood of individual harm, extended lengths of stay and/or unplanned readmissions. For health services, ratios offer the opportunity to implement a direct care staffing methodology that is evidence-based, easily comparable and delivers improvements in the safety, quality and cost of healthcare. Investing in nurse-to-patient ratios and endorsed skill mix levels aligns with the safety and quality agenda and is a clear win for those who use, provide and fund healthcare.

A growing body of national and international research and evidence clearly demonstrates the benefits gained from the implementation of safe mandated minimum nurse and midwife staffing. It also clearly demonstrates that inadequate nurse and midwife staffing leads to an increase in negative outcomes for patients, which results in increased health care costs.

*Analysis of the implementation of nurse-to-patient ratios in the US found if nurse-to-patient ratios of 1:4 were implemented nationally, 72,000 lives could potentially be saved each year. The researchers found that when nurses saved patients from pneumonia, they saved US\$4,000-US\$5,000 a day. When nurses prevented an adverse drug event, they saved US\$1,520 a day.*

*Research has demonstrated that the costs of additional nurse staffing is justified when the costs of adverse events are calculated. It has shown that while increasing nurse staffing by one registered nurse hour per patient day (HPPD) added US\$659 to the "cost per case", each additional adverse event increased the cost per case by US\$1,029 for medical patients, and US\$903 for surgical patients. Costs varied according to the type of adverse event, with urinary tract infections associated with a US\$1,005 increase per case, and pressure ulcers even more expensive at US\$2,384 per case.<sup>16</sup>*

In Australia, a Queensland Parliamentary Committee reviewed the evidence of the efficiency and effectiveness of nurse-to-patient ratios prior to passing legislation mandating ratios in Queensland's public hospitals. The review concluded that:

*The evidence strongly supports that safe nurse-to-patient ratios lead to significant improvements in patient outcomes. Evidence also indicates that appropriate staffing numbers benefits the nursing workforce by reducing work-related injuries, absenteeism and turnover and increasing job satisfaction. Government Members also noted the significant evidence of economic benefits, in addition to improved patient outcomes, achieved through the implementation of a safe nurse-to-patient ratio.*

---

<sup>16</sup> More detailed analysis of the cost benefits of nurse to patient ratios can be found at:  
<http://www.nswnma.asn.au/wp-content/uploads/2013/07/Benefit-of-more-nurses-booklet.pdf>

A detailed examination of the benefits of nurse-to-patient ratios in terms of improving patient outcomes and cost effectiveness is outlined in the Committee's full report.<sup>17</sup>

### **Information patients should have to make informed choices about public hospital services**

The ANMF considers that patients should have access to information regarding nurse and midwife staffing levels and patient health outcomes at all public hospital facilities. This should form part of the mandatory public reporting requirements for public hospitals.

Measurement and reporting of patient health outcomes can be achieved by developing minimum data sets aligned with the area of chronicity/model of care/clinical discipline. Measuring and reporting these outcomes is critical to assessing whether clinicians and the models of care used are actually improving the health of patients. It also provides evidence of the contribution of non-medically led models of care to inform future investments in health (e.g. nurse-led and nursing-based services).

There are 7 states in the USA that publically report nurse staffing levels – based on legislation. Currently there is no federal legislation in the USA however a Registered Nurse Safe Staffing Bill was introduced in 2015. A review of the 7 states has shown a diverse range of ways to publicly report this nurse staffing level however there are a number of crossover points such as providing an overall view, quality measures, safety measures, satisfaction measures, speciality services performance and staffing/beds.<sup>18</sup> These factors should be included in public reporting to support the overall argument for patient safety and the delivery of high quality healthcare.

Consumers of health care should have the right to choose public hospitals and services which demonstrate safe staffing levels and good patient outcomes. Including these factors in mandatory public reporting could also provide public hospitals with incentives to meet benchmarks for improved health outcomes overall.

### **Improved technology**

Another consideration for improving efficiency in public hospitals is through better use of technology.

Technology can better support connections between primary and hospital care by:

- Creating an open infrastructure that allows multiple providers to connect to the same health information
- Improving the timely access to patient information for all clinical disciplines
- Permitting patients to access their own information to promote self-management and empowerment.

---

<sup>17</sup> Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee April 2016, Hospital and Health Boards (Safe Nurse-to-Patient and Midwife to-Patient Ratios) Amendment Bill 2015, *Report No. 18*. Available online at: <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2016/5516T587.pdf>

<sup>18</sup> Further details of this review can be provided on request.

Technology can be used to improve patient outcomes remotely by:

- Supporting the patient to actively participate in self-management
- Supporting the delivery of team-based services across the health care continuum
- Amalgamating with financial incentives to drive users to adopt best practice care and wellness management process for patients
- Monitoring and reporting trends in patient outcomes for the purposes of continual quality improvement.

It is also clear that optimising technology enablers is vital. The enablers needed to support the increase use of technology to improve team-based care include:

- Access to basic infrastructure, reliable equipment and services (e.g. internet)
- No or low set up and ongoing costs for patients and the providers
- Education, training and support services for patients and providers
- Systems which are compatible and accessible by multiple providers (e.g. pathology and radiology, primary and tertiary health providers)
- Processes that promote and deliver patient privacy
- Development of change management plans for patients and providers
- Strategies for those patients unable to use technology (e.g. older persons, patients experiencing mental health condition and those experiencing disabilities).

## **END-OF-LIFE CARE**

This submission supports the comments and evidence provided by the Queensland Nurses' Union (ANMF Queensland Branch) in its submission to the Inquiry<sup>19</sup> with regard to: ways to improve the implementation of choice in end-of-life care, quality of care – quality of life, the role of nursing in this highly specialised area, the need for improved palliative care and nurse and carer staffing in aged care and the need for strengthened accountability for public funding in aged care.

---

<sup>19</sup> Queensland Nurses' Union, 2017, Submission to the Productivity Commission, Reforms to human services, pp. 4-15.

## FURTHER RECOMMENDATIONS – ALTERNATIVE POLICY/ALTERNATIVE FUNDING

A list of further recommendations for health savings is provided below. Detailed information about these recommendations can be provided if required. However, substantial detail and analysis has been provided by many health experts and health groups to the Federal Government over the last two years. It appears though, that the Government remains unwilling to recognise or act on this advice.

### Restore and implement constructive Partnership Agreement

- Need to return to funding models that recognise growth and use incentives to encourage efficiency.
- Restore National Health Partnerships Agreement, which crucially aligned interests of states and the Commonwealth, thereby addressing cost-shifting.
- Implement policy incentives which focus on improvements to safety.
- Move from a volume-based to a value-based health care system to assist health care providers to refocus on delivering health outcomes rather than meeting activity targets.
  - Value-based systems promote increasing the value for patients in terms of the number of health outcomes achieved as opposed to the number of visits made and prioritise achieving and maintaining good health as a mitigation strategy to the more costly care associated with poor health.

### Increase access to primary care and prevention

- Increase incentives to encourage changes in both health provider behaviour and individual behaviour.
- Investigate better and more efficient ways to fund and manage chronic conditions, e.g. blended payment models.
- Establish funding arrangements which support the use of a wider range of health professionals in chronic and complex care.

### Protect the universality of Medicare

- Ensure that Medicare remains as Australia's universal health insurance scheme (the most efficient insurance scheme), and does not become reduced to a 'safety-net'.
- Contain the role of the private sector and the private health insurance industry as a complement to the public health system.
- Prevent inappropriate and unnecessary expansion of the private sector and the private health industry, e.g. ensure that PHI companies are restricted from operating in primary care. Allowing PHI companies into this domain will increase inequity and reduce efficiency.

### Cut pharmaceutical prices

- Renegotiate the pricing agreement between the Government and the drug companies, with changes that would cut wasteful spending by at least \$1.3 billion a year

### Increase value of private health insurance for all consumers of health care

- Remove the public subsidy of PHI. This could be done gradually –
  - A 10% reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals with less than a 2% reduction in private health insurance coverage.<sup>20</sup>
  - Ancillary rebates could be cut, starting with removal of rebates for luxury items (e.g. gym memberships, running shoes and relaxation CDs) and treatments for which there is no sound evidence base.
  - Alternatively, reduce the other subsidy to the private sector: Medicare items for procedures, diagnostic imaging and pathology, which largely go to private hospitals.

### Improve workforce utilisation

- Allow nurses and midwives to work to their full scope of practice.
- Significantly increase the numbers of nurse practitioners and eligible midwives and ensure that there are positions made available for them.
- Expand roles for other health professionals as appropriate, e.g. occupational therapists and pharmacists who should be better integrated with primary care and other health professionals.
- Review the MBS to remunerate a wider range of health professionals, at appropriate levels and funding models.

### Investigate alternative revenue sources

- Reform tax concessions - limit access to growing tax concessions such as superannuation, which bring most benefit to those with high incomes, to provide additional funding for essential public services.
- Introduce a *Robin Hood* tax – The ANMF believes rather than disadvantaging ordinary people through tight budget measures it is time the Government took and redistributed a larger share from those involved in the billions of dollars in financial transactions. The ‘Robin Hood’ tax, also known as a financial transactions tax, is a 0.05% tax on institutional trades of currencies, stocks, bonds, derivatives and interest rate securities. It is widely implemented across the European Union. If governments can tax ordinary Australians on basic requirements such as housing, then they certainly can and should tax international financial transactions.

---

<sup>20</sup> Cheng, T.C. 2014, Does Reducing Rebates for PHI Generate Cost Savings?, Melbourne Institute Policy Brief No. 3/13, Online: [http://www.melbourneinstitute.com/downloads/policy\\_briefs\\_series/pb2013n03.pdf](http://www.melbourneinstitute.com/downloads/policy_briefs_series/pb2013n03.pdf)