THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to The Competition Policy Review Panel

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Queensland Nurses' Union
106 Victora St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
P (07) 3840 1444
F (07) 3844 9387
E qnu@qnu.org.au
www.qnu.org.au

Introduction

The Queensland Nurses' Union (QNU) thanks the Competition Policy Review Panel (the panel) for the opportunity to comment on the *Competition Policy Review Draft Report* (the draft report).

Nurses[1] are 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 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Our submission responds to draft recommendation 2 – Human Services – of the draft report that reads:

> *Australian governments should craft an intergovernmental agreement establishing choice and competition principles in the field of human services. The guiding principles should include:*
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> - *user choice should be placed at the heart of service delivery;*
> - *funding, regulation and service delivery should be separate;*
> - *a diversity of providers should be encouraged, while not crowding out community and voluntary services; and*
> - *innovation in service provision should be stimulated, while ensuring access to high-quality human services.*
>
> *Each jurisdiction should develop an implementation plan founded on these principles that reflects the unique characteristics of providing human services in its jurisdiction.*

We recognise that the panel's recommendations were made within the context of competition policy, however we strongly oppose the elevation of market based principles in health service provision at the expense of government in providing free, high quality,

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including RNs, Midwives, ENs and AINs.

accessible health care. 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 and it is the role of government to fund and provide it. We are not saying there is no role for competition, rather that competition principles must not replace a fundamental responsibility of government towards is citizens. To that end, we see in the draft report, a similar philosophy to that guiding the recent National Commission of Audit (the audit commission). The Commission's recommendations and those put forward in the draft report are at odds with our view of health care delivery, particularly as these two bodies are seeking to reorient fundamental understandings about competition and the role of government.

National Commission of Audit as an Ideological Platform for Health Policy, Administration and Expenditure

In October, 2013, the federal Treasurer, Joe Hockey, and the Minister for Finance, Senator Mathias 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. Given the partisan membership of the audit commission[2] and the nature of its terms of reference, there was no possibility the reports would represent an independent assessment of the national finances. Less than two weeks after releasing the audit commission's reports, the Abbott Government brought down its 2014-5 budget. The budget has been the instrument for implementation of a number of the audit commission's recommendations on health spending or variants of them.

[2] The Abbott Government appointed Tony Shepherd to chair its audit commission. At the time Mr Shepherd was president of the Business Council of Australia (BCA), a position he had held since late 2011. He was also chairman of listed company, Transfield Services, between 2005 and October 2013. The other Commissioners also had connections with the BCA or the Liberal party.

This marks the beginning of a wide-ranging agenda to change Australia's health system through economic policy based on neo-liberal principles of small government and large private interests. This is an outdated ideology that finds its origins in the 1980s moves to dismantle the mixed economy and reduce the role of government.

The QNU rejects the basic assumptions on the role of government and the attempt to refashion the Australian economy and health system through competition policy (as well as the federal budget). The QNU believes government has a vital and effective role to play in the delivery of quality, cost effective health services.

Government provision of health care

The QNU believes healthcare based on clinical need is a human right and patient care must always take precedence over profits. The QNU is very concerned about the Abbott government's long-term health agenda signalled by its message that the current system is 'unsustainable'. The audit commission's recommendations indicate the 2014 federal budget is a first step towards shifting the vast majority of people onto private health insurance where Medicare will become a government 'safety net' arrangement for the 'most' disadvantaged.

In Section 7.3 of its phase one report, the audit commission (2014) states:

> Recent Productivity Commission projections suggest Commonwealth Government spending on health will rise from around 4 per cent of GDP in 2011-12 to 7 per cent in 2059-60. Health expenditure by State governments is projected to rise from around 2.5 per cent of GDP to almost 4 per cent of GDP over the same period. Other research projects similar trends.

Richardson (2014) has claimed that the unsustainability of government health expenditure in Australia is a myth that has been carefully nurtured to justify policies to transfer costs from government to the public. According to Richardson (2014)

> The fear that the rising share of GDP spent on health will harm the economy or our standard of living – reflected in numerous reports for the government, including the recent National Commission of Audit's – is probably a result of bad arithmetic.
>
> It's entirely possible for spending on health to rise more rapidly than GDP and for the amount of non-health GDP to continue to rise.

> If GDP growth per capita fell to the annual average of 1.4% per annum, which occurred between 1970 and 1990, then by 2050 per capita GDP would rise by 65%. And if health expenditures rose to the US level of 17.7%, there would still be a 50% increase in non-health GDP per capita.
>
> The unsustainability myth is created by focusing on percentages and not on the absolute level of resources available. Health spending probably will rise as a share of GDP, but the economy is flexible. In 1901, agriculture accounted for 19.5% of GDP; today it is 2%.
>
> The composition of GDP varies with technology and demand, and increasingly (as agriculture and now manufacturing, decline in percentage terms), services – including health services – have expanded.

Other eminent economists such as Saul Eslake, support Richardson. Eslake (quoted in Swann & Hunter, 2014) claims a modest rise in health spending was inevitable as Australians grew richer and older and that 'to call it unsustainable is probably an exaggeration'.

Duckett (2014) concurs. Far from having a health funding crisis, Australia has "one of the best health systems in the world". According to Duckett (quoted in Swann & Hunter, 2014) Australia has less than the OECD average on health spending per capita and has better than the OECD average on life expectancy. So in reality Australia is in 'the healthcare system sweet spot'.

As Richardson (2014) has also pointed out, the real problem seems to be 'a dislike of communal sharing even when it is to alleviate the financial burden of those already disadvantaged by illness'.

The latest report of the Australian Institute of Health and Welfare (AIHW) (2014a) indicates Australia is in no particular peril in this area. According to the report, spending on health in 2012-13 slowed to record low levels. Total spending on health goods and services in Australia was estimated at $147.4 billion in 2012-13 (9.67 per cent of GDP). This was merely 1.5 per cent higher than in 2011-12 and barely the OECD average. This represents 'the lowest growth the AIHW has recorded since the *Health expenditure Australia* series began in the mid-1980s, and more than three times lower than the average growth over the last decade (5.1 per cent)' (AIHW, 2014b).

The report shows government spending on health overall fell by 0.9 per cent in 2012-13. This was largely due to a fall of 2.4 per cent in the Australian government's funding. During the previous decade, Australian government spending had experienced average annual growth of 4.4 per cent.

The main reasons for the decrease in federal government spending were reductions in the Pharmaceutical Benefits Scheme, public health, dental services and e-health. Spending also fell in health insurance premium rebates, veterans' affairs and tax rebates.

The report also shows that growth in sub-national government funding was low. State and territory health spending grew by just 1.4 per cent in 2012-13, 4.2 percentage points lower than the average growth for the decade.

In 2012-13, governments funded $100.8 billion or 68.3 per cent of total health expenditure in Australia. This was 1.6 percentage points lower than in 2011-12, the largest reduction of the decade. The Australian government's contribution was $61.0 billion (41.4 per cent of total funding) and state and territory governments contributed $39.8 billion (26.9 per cent).

Non-government funding sources provided the remaining $46.6 billion (31.6 per cent). The non-government share rose by 1.6 percentage points, with individuals contributing over half of the increase (0.9 percentage points).

In 2012-13, estimated spending per person on health averaged $6,430, which was $17 less per person than in the previous year.

The draft report states that ‘Australian will demand more government services over time, especially in health and education as our population ages…’ (p.17). In light of the evidence that suggests health spending is not at the critical levels the federal government claims, ‘diversity, choice and responsiveness in government service’ are already possible within the current health system.

Privatisation

In our view, creating a crisis in health spending provides the federal government with the impetus to promote and implement its agenda to privatise the health sector through a mantra of ‘deregulation’ and ‘choice’.

In Section 7.3 of its report the audit commission (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 resonate in the draft report and its aims to change competition policy settings. Various state governments have experimented with privatisation of hospitals and it has been less than successful in most cases. The Queensland government recently 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.

In various States, governments have had to resume the running of a several public hospitals or bail them out after private sector failures (see for example the unsuccessful privatisation of Modbury Public Hospital in South Australia, Robina Hospital in Queensland, Port Macquarie Hospital in New South Wales and Mildura Base Hospital).

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.

To commence this process, the audit commission recommends a number of initial changes to reduce spending on healthcare and hospitals and force high income earners into private health insurance.

Section 7.3 of the audit commission's phase one report (2014a) calls for a broader, long-term review (encapsulated in Recommendation 18) with a heavy emphasis on privatization ideas such as a universal health insurance arrangement. Such a scheme would make health insurance mandatory for all Australians. The Commonwealth would pay premiums for low income and high risk groups and also pay for the health insurance of all children. It would be compulsory for people on higher incomes to take out private health insurance.

Medicare would remain as the default insurer for those on lower incomes, with their premiums paid by government direct to Medicare. People on low incomes could alternatively choose a private health insurer, with their premiums still paid by the government.

The QNU strongly opposes this type of policy change. Here 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.

The public hospital and private health insurance proposals will reverse decades of achievement by those who built our public hospital system – often in the face of determined opposition from powerful vested interests in the private and medical sectors.

Public Hospital Funding

Another 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 announced in the 2014-15 budget. The federal government is urging the States and territories to drive productivity and efficiency improvements in public hospitals to rein in expenditure growth. Commonwealth funding to public hospitals will increase every year but from 2017-18 the government will introduce revised funding arrangements 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. This unanticipated move has angered most Premiers and will no doubt be the subject of further detailed negotiations. While the Queensland Premier is decrying this action by the federal government it is important to remember that his government has been responsible for unprecedented job and service cuts in Queensland Health.

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 is concerned that health services will continue to decline if the Newman government in Queensland persists in undermining the state's free public hospital system. It cannot continue to hide behind local hospital boards, the health payroll problems, the *National Health Reform Agreement* or any other diversion as it implements its outsourcing and privatisation policy.

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 Abbot 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).

Almost **1800 Full Time Equivalent (FTE)** nursing and midwifery positions have been cut from the public sector since September 2012 out of an overall total of over **4800 FTE** job losses in Queensland Health[3], with devastating impacts for health workers and the communities they serve. The same small government, pro 'choice' agenda that drives the Queensland LNP government also propels the Abbott Coalition government, just as their respective Commissions of Audit provide the ideological platform for their budget cuts and competition policy.

Aged care

Despite several years of campaigning for greater regulation in the aged care sector and equitable payment for nurses, the 2014 budget transferred the $1.5 billion in funding intended for the aged care Workforce Supplement to the general funding stream. This means residential and community care providers have received the increase without needing to sign enterprise agreements, or sanction any other mechanism that would entitle nurses to wage justice.

Nurses working in this sector will continue to receive significantly less wages than their colleagues in the public and private sectors. This in turn often results in an inadequate skills mix[4] because of the shortage of Registered Nurses 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.

[3] These figures are accurate as of 30 October and are based on information supplied to the QNU from Queensland Health. Despite orders from the Queensland Industrial Relations Commission, the QNU has had to make numerous Right To Information requests to obtain correct data on the number of abolished positions.

[4] This refers to the most appropriate mix of staff required to provide safe, quality care and is based on the ratio of Registered Nurses to other nursing staff.

While we note that regional, rural and remote aged care providers will receive an additional $54 million over the next four years, the 2014 budget also abolishes the payroll tax supplement paid to the for-profit residential care providers and this will put more pressure on staffing and wage levels. These are the realities of aged care.

The QNU will continue to campaign for greater regulation and accountability, not less, in key areas of aged care including:

- 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;
- improving nursing staffing numbers and skill mix so staff can provide quality, safe care;
- improving transparency and accountability in government funding and consumer payments; and
- licensing of all workers, including assistants in nursing/personal carers and irrespective of whatever job title their employer might give them, providing nursing in aged care.

Other Health Care Measures

End of Medicare Locals

From 1 July 2015, the federal government will establish new Primary Health Networks with a smaller number of local networks replacing Medicare Locals. The Primary Health Networks will have General Practice as the cornerstone and be clinically focused and responsible for ensuring that services across the primary, community and specialist sectors work together in patients' interests.

The government will also explore models of primary health care funding and coordinated delivery, including partnerships with private insurers.

We question a greater role in primary health care for private insurers. We are aware that in recent years, some insurers have been testing opportunities to expand their involvement in primary care, through measures to reduce hospital admissions (and therefore, costs) by keeping their members healthier. Insurers are currently restricted in their offerings in primary care (Wells, 2014). We do not support any measures to remove this restriction as

private insurance for the GP fee gap would likely put upward pressure on GP fees overall, thus making it more expensive for those without private coverage.

The QNU believes the government cannot continue to compromise access to GP care through co-payments or private insurance coverage of the GP fee gap.

Health agencies to close or merge

The government will transfer to the Department of Health the essential functions of:

- the Australian National Preventive Health Agency;
- Health Workforce Australia;
- and General Practice Education and Training Ltd

with a view to closing these agencies. Other changes to agencies include:

- The functions of the Australian Organ and Tissue Donation and Transplantation Authority and the National Blood Authority will be merged with a view to establishing a new independent authority.
- The Private Health Insurance Ombudsman's responsibilities will be transferred to the Office of the Commonwealth Ombudsman.
- The functions of the Private Health Insurance Administration Council will be transferred to the Australian Prudential Regulation Authority and the Department of Health with a view to closing the agency.
- Back office functions between the Department of Health and the Australian Sports Commission will be shared.

During 2014-15, the federal government has indicated it will work with states and territories to create a new health productivity and performance commission. Subject to consultation, the new commission would be formed by merging the functions of:

- the Australian Commission on Safety and Quality in Health Care;
- the Australian Institute of Health and Welfare;
- the Independent Hospital Pricing Authority;
- the National Hospital Performance Authority;
- the National Health Funding Body; and
- the Administrator of the National Health Funding Pool.

While the Health Minister and Minister for Finance (Dutton & Cormann, 2014) claim that 'the creation of new structures and layers of bureaucracy was wasteful and their functions

could be streamlined', we argue that any merger or closure of government agencies should not come at the expense of proper monitoring and enforcement of safety and quality standards and public access to information.

The QNU is particularly keen for the work of the National Hospital Performance Agency to continue and expand to provide comprehensive information on private and public hospitals. This is of significant public interest and vital to monitoring any competition policy initiatives.

Industrial Relations Framework

The draft report does not refer to the industrial relations framework that will enable competitive service delivery, safe workloads, or conditions necessary to quality of care. This is an important omission as many of the identified measures will need to be implemented through consultative mechanisms enabled by industrial instruments.

It has been the experience of the QNU that co-operative workplace relations through Interest Based Bargaining (IBB) and an Interest Based Problem Solving (IBPS) approach to workplace change and implementation of enterprise agreements facilitate effective improvements in strategies to recruit and retain a nursing workforce. IBB and IBPS build on the 'integrative' bargaining concept. It is distinguished by a focus on the parties' interests rather than their positions or the outcomes they seek. The parties acknowledge that they can have shared, conflicting or different interests, but work in partnership to achieve durable outcomes.

A co-operative approach such as IBB/IBPS is an essential ingredient in improving the quality and delivery of health services. Difficult enterprise bargaining negotiations in the public sector do little to improve community perceptions or gain support for the government or unions. Through the negotiation and implementation of three enterprise agreements, the QNU and QH have demonstrated the potential value for IBB/IBPS in addressing contemporary organisational and workforce issues. This scheme has delivered benefits for both parties, however the actions of the Newman government in relation to industrial relations reform clearly indicate its lack of support for an IBPS approach into the future. Indeed, the Newman government's legislative changes to industrial relations will severely undermine co-operative relationships and the problem solving approach that is so crucial to competition and productivity improvements in the health system.

It is our firm belief based on many years of experience that it is cooperation and not competition that underpins the delivery of quality patient centred outcomes in health and aged care.

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 the core elements of competition policy.

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