National Competition Policy Review of the Nursing Act 1992

24 January 2002

1. Introduction/Review Background

1.1 Purpose of the Review

In our previous submission to this review of the *Nursing Act 1992* the Queensland Nurses' Union (QNU) outlined our general serious concerns about the appropriateness of applying National Competition Policy (NCP) principles in the health sector. We wish to reiterate some particularly important aspects of these concerns again and also delve more deeply into the notion of the application of competitive market principles in health generally and in particular to the practice of nursing.

Firstly, the QNU rejects the assumption inherent in the competitive model – namely that competition in itself is always a worthwhile objective in its own right. In this model competition is an unquestioned virtue, one that assumes paramount importance in its own right. The QNU is particularly concerned that the implementation of NCP has been driven by economic imperatives at the expense of social welfare considerations and the notion that competition will in itself lead to increased efficiency. The assumption appears to be that both competition and efficiency are always intrinsically beneficial and socially desirable objectives. The flaws of these assumptions are apparent in a number of sectors where NCP has been applied.

The application of the competitive model in a sector such as health must be done with extreme caution and on a case by case basis given that it is *"in the health sector where we almost certainly encounter the most complex market conditions in the economy."* (Watts J, 1.15) The problems of applying a narrow competitive model in health have received considerable attention in the discipline of Health Economics.

There are difficulties associated with applying competitive models to health generally. We will highlight some of these difficulties. It is then important to highlight how nursing differs from other health professions, and in the process expose that these issues have not been given appropriate attention to date in the debate around the application of competitive principles to nursing.

In theory perfectly competitive markets are based on four assumptions that: there are many independent firms and consumers in the market, all firms are producing identical products, firms can enter and exit the market freely and both firms and consumers have "perfect information". (Pindyck and Rubinfeld, p 283-284) In reality perfectly competitive markets rarely, if ever, exist. It is obvious that "market" in health fails to meet this model in many ways. This is due to factors that are intrinsic to health. For example, in health care markets "perfect information" is particularly problematic, as "information asymmetry" is inherent in the transactions that occur between providers and consumers (as indeed it is in the provision of professional services generally).

Sources of "market failure" in health are many and varied and require government intervention in health markets. The sources of market failure that are intrinsic to health are summarised by Watts (p2.4-2.6). She highlights that these relate to issues such as externalities, the need for the provision of public goods (and hence why public monopolies in such instances may be more efficient), quality assurance and the need for protection of the community, the complexity of the relationship between health and the consumption of health services, the provider as agent, moral hazard and supplier induced demand and adverse selection. It is not appropriate or necessary to explore all these issues in detail now. It is suffice to say that the health market is significantly different to other markets and it has its own inherent complexities. This in not an argument for not examining the health system, rather we question the appropriateness of applying such a theoretical model in an uncritical manner.

There are many sound reasons why it is not appropriate to apply competitive principles in an industry such as health. The QNU believes that maximising outcomes (and efficiency) in the health "industry" is largely predicated on cooperation between all players, not competition. Most importantly in our view are the moral or ethical components to "transactions" in health. Because of this it is not possible to reduce transactions

in health to the status of transactions that occur in the marketplace. Instead what may require analysis is not whether the health system, the legislation that governs it (including regulation of the professions) and the practices in the health system "survive" an analysis under NCP principles but rather whether it stands up to ethical analysis. Maybe more tools are required that facilitate ethical analysis, not economic analysis. An examination of one important feature of health, the nature of information asymmetry highlights these inadequacies.

Information asymmetry results in the provider of health services acting as the agent for the consumer. The complexity of and difficulties associated with this agency relationship are often not acknowledged, especially when it is the case that the agent has a vested interest in the advice/service being given. This is especially the case where a fee for service arrangement exists. Such arrangements are not an established feature in nursing. Indeed this is a significant issue that needs to be highlighted as part of this review.

Nursing differs from other regulated health workers such as many doctors and dentists and some allied health professionals where a fee for service arrangement exists and the profession sets the fee schedule. Very few, if any nurses operate under a "fee for service" arrangement. (It is also important to remember that not all doctors, dentists and allied health professionals operate under such arrangements.) Remuneration arrangements for nurses are established under the auspices of independent industrial relations tribunals. Direct employment by a government department or health agency is the normal employment arrangement for nurses. This is also the case for the emerging Nurse Practitioner role in Australia.

Some may argue that the absence of a "fee for service" arrangement means that nursing does not meet the strict definition of a profession. We wholeheartedly reject this assertion. Nursing in Queensland is self –regulated through the Queensland Nursing Council, is based on a significant body of technical expertise and is governed by a code of conduct. To us, fee for service arrangements that characterise some other health professions are not inherent to the nature of professions. They are indeed a potential source of conflict for ethical professional practice given the nature of transactions that occur between provider and consumer, particularly given the information asymmetry (and hence power imbalance) that exists. Such arrangements may have developed over time to become a feature of some professions. It is even possible to argue that such fee for service arrangements are encouraged by or are in part a result of the power imbalance (information asymmetry) that exists between the provider and consumer. In summary, remuneration and associated issues (such as the control of the supply of professionals in order to affect the supply of such services) may result from an abuse of "market power" (and institutionalised power) but are not inherent features of professions.

We are labouring this point because we believe that this is an important issue and one that has not received enough attention to date. Nursing differs from other professions that may have abused their market and other forms of power in the past. Nurses do not set their own fees, we do not place onerous limitations on entry into specialty areas (indeed we are currently doing all within our power at present to ensure that the critical shortages that exist in nursing specialties are addressed as a matter of urgency) and we can not be accused of supplier-induced demand. We believe that we can justify the regulation of nursing in the name of public interest – such protection is required to protect not only the sick but the health of the community in general. In our view the benefits of such regulation far outweigh the costs. We also believe that the objective of the *Nursing Act 1992*, *"to make provision for ensuring safe and competent nursing practice"*, can only be achieved by "restricting competition". That is, the safety of the community can only be assured by regulating nursing practice and those who can undertake it.

Our fear is that the assumption is that nursing operates in the same way in which other professions that indulge in so-called "anti-competitive" (some may prefer to use the term "unethical") behaviour. This demonstrates a fundamental lack of understanding of the health system and the manner in which the professions who work in that system operate. In our view this review and in the general debate on the application of NCP to health, the complexities of the health context and power imbalances (not only between consumers and providers but also between the various providers in the system) have not been adequately acknowledged.

The Australian Competition and Consumer Commission (ACCC) has made no secret of the fact that they are paying particular attention to "anti-competitive" behaviour on behalf of the professions. There has been considerable media attention given to the ACCC's view on actions of some professions in health, most notably medical specialists. We contacted the ACCC in the course of formulating this submission and asked whether they had shown any particular interest in the regulation of the nursing profession and whether they had an understanding that nurses do not operate under a "fee for service" arrangement nor is the profession involved in setting their fee schedule. We were advised that little, if any consideration has

been given to nursing to date. Given that nurses make up the largest single professional group in health we find this quite astounding. We are concerned that this indicates a fundamental lack of understanding of the way in which the various professions operate within the health sector. We are also concerned that a rather uncompromising approach may be taken to all health professions. Has the ACCC clearly identified the types of behaviours that they consider "anti-competitive", who is involved in this, quantified the impact of this behaviour and then examined all possible avenues for remedy?

In a recent speech to the Centre for Health Program Evaluation at Monash University, Professor Allan Fels outlined the ACCC's concerns about how the professions are affecting the efficient delivery of health care in this country. In this speech he highlighted some valid and longstanding issues of concern that need to be publicly examined and debated. Near the end of his address (Fels, p 20) he made an important contextual differentiation:

"I believe that professionals, including doctors, and lawyers, and dentists, should be treated no differently to others engaged in supplying services and goods to the public ***and who choose to operate as businesses****."* (emphasis added)

If regulatory frameworks exist that are acceptable to both the community and the professions and ensure ethical behaviour (even when a professional chooses to operate as a business) then would it be necessary to apply an economic framework to address behaviours that negatively impact on the common good? Is it the case that the actions of a few may have called the actions of all into question? What are the implications for those professionals who do not act as businesses? The application of theoretical economic dogma will not address these issues that essentially relate to power imbalances and ethical behaviour. Central to addressing these concerns is access to meaningful information by consumers that enable informed choice and mechanisms to address, as far as is possible, power imbalances in health. This is a significant agenda. The NCP review processes of the professions may highlight issues of concern but we believe that the remedies required are the responsibility of government, as elected representatives of the community, not the market.

Governments determine that such regulations are necessary in the interest of public safety. Some argue that regulation of this nature provide unnecessary barriers to competition. The alternative view is that such minimum regulations are required to be set by government because the market, left to its own devices, will not ensure the public good. There are costs to both government and private health care providers associated with the administration of such regulatory frameworks but there are also obvious benefits as well. Government, on behalf of the community as a whole, conducts analyses of the costs and benefits of such regimes and legislates and administers accordingly.

We are pleased to see that the current government has moved away from an unquestioning approach to the NCP. The Queensland Treasury document titled *Public Benefit Test Guidelines: Approach to undertaking Public Benefit Test Assessment for Legislation Reviews under National Competition Policy* details the change in the government's approach to such reviews. This document details (at p 6-7) the undertakings given under the Competition Principles Agreement (CPA) that:

" … legislation should not restrict competition unless it can be demonstrated that:

- *The benefits to the restriction to the community as a whole outweigh the costs; and*
- *The objectives of the legislation can only be achieved by restricting competition*

This means that NCP reviews must not only consider whether an existing/proposed restriction provides a public benefit, but also whether other options would achieve a greater public benefit."

The last sentence of this quote highlights an important point that is relevant to the current review of the *Nursing Act 1992*. The November 2001 Discussion Paper highlights some examples of potential inadequacies of the current regulation of nursing practice in Queensland. A number of issues highlighted in the discussion paper are also of concern to the QNU, and were highlighted in our previous submission to this process. The first relates to the need for the Queensland Nursing Council to regulate those people who are currently not regulated by the council and yet are carrying out nursing practice (at times without the supervision of registered nurses). The second issue highlighted in the discussion paper is the need for a clear and concise definition of "nursing practice"(that is suitable for legislative purposes). This second issue is perhaps more difficult to address than the first. However, in our view attempts should be made to improve the current legislation so as to strengthen the benefits to the community. Although this may not be possible through a legislative definition other avenues to address this issue need to be investigated as a matter of urgency. (Our interpretation of "other options" includes the strengthening or clarification of current provisions, not the replacement of regulation with other forms so called "regulatory alternatives".)

Another important point made in this Treasury document is found in a following paragraph (p 7):

"The need to carry out the review of legislation recognises that government regulation can sometimes create unwarranted barriers to entry or other restrictions on business which limit consumer choice, stifle innovation and reduce incentives for achieving better efficiency. ***However, the review of legislation does not imply a need to introduce or ensure competition for its own sake nor imply that competition objectives should take precedence over other important public policy objectives****."* (our emphasis)

This is a critically important shift in policy approach by the Beattie government that is welcomed by the QNU. A fundamental criticism that the QNU has of past application of NCP has been that too often competition for competition's sake has been an overriding objective, at the expense of other equally (or more) important objectives such as equity, access and effectiveness. Under the nationally consistent approach to the annual reports on government service provision includes the need for the development of indicators to measure such outcomes. (See *Report on Government Service Provision 2001*.)However, to date undue emphasis has been placed on the development of indicators to measure efficiency. A number of efficiency (unit cost) indicators have been developed for public hospitals, (eg Recurrent cost per casemix adjusted separations, Labour costs per Casemix adjusted separations, User cost of capital per Case mix adjusted separation, Casemix adjusted relative length of stay and under development is the indicator Cost per non-admitted occasions of service). However, work on developing effectiveness indicators (covering areas such as quality, appropriateness and accessibility and access) has for too long been wanting. In our view indicators of outcomes that are not related to efficiency outcomes in health are an integral part of the PBT assessment of legislative reviews affecting the health sector. Until such time that these are developed it would be inappropriate to base decisions on whether legislative changes are warranted until such time that these are developed.

Further to this, the Queensland Treasury document states (p 8) *"that the combined effects of the costs and benefits to the community must be assessed against the Government's Priority Outcomes."* These are:

" More jobs for Queenslanders

Building Queensland's regions

Skilling Queensland

Safer and more supportive communities

Better quality of life

Valuing the environment

Strong government leadership" (p 8)

We believe that assessments of the impact of the application of NCP principles to nursing regulation has an impact in most of these priority outcome areas, therefore making this review all the more complex. Will the final Public Benefit Test document assess against all of the above criteria, and if so why haven't those making submissions to this review been requested to make comment on these to assist the formulation of the PBT report?

It is also important to remember that there is a broader context to consider. All of the issues of concern that we have raised in this section highlight the complexity of applying a competitive model used in the "trade of goods" to the "trade of services". This debate is of international significance given the undertakings given to date by the Australian government to international bodies such as the World Trade Organisation (WTO) in the current round of General Agreement on Trade in Service (GATS) negotiations.

Finally, as part of this review process it is essential to revisit the original objectives of the *Nursing Act 1992*. These must be kept at the forefront of this review process. The objective of the act is: *"to make provision for ensuring safe and competent nursing practice"*. Further exploration of this issue can be found in the second reading speech of the Bill by the then Minister for Health, Hon Ken Hayward. This stated in part:

"Although it is true that regulation of a profession is a benefit to the members of that profession – a benefit which accrues by virtue of status afforded through Government recognition, and in being able to self-regulate – the main purpose of such regulatory activity is of increasing importance today to both the public and the Government. That purpose is if course, consumer protection. Hence the objective of the Bill explicitly refers to "ensuring safe and competent nursing practice. I believe that the role of regulatory bodies such as the Queensland Nursing Council, will expand, particularly with the Health Rights Commission becoming operational from 1 July 1992, so as to eventually provide a fully integrated consumer protection system in Queensland." (Hansard, 5 November 1992, p 78)

He concluded this speech by stating:

"This Bill is a progressive piece of legislation. It is one which makes provision for the many changes that are occurring in nursing, and it does this in such a way that I see certain features of it acting as the model for review of legislation governing other professional registration boards under my portfolio. I commend the Bill to the honourable members of this House." (Hansard, 5 November 1992, p 80)

From these Hansard extracts it is apparent that the overriding concern of the government at the time was consumer protection. This must remain the overriding concern of the government of today during this review process. It is also apparent to the QNU that the Health Minister at that time saw this legislation as a "model" for legislation governing other health practitioners. At the same time he envisaged the strengthening of consumer protection though other related reforms (eg through its relationship with legislation governing the Health Rights Commission). Whether this strengthening of consumer protection has indeed occurred since 1992 must be considered as part of this review, as should how effective other related bodies such as the Health Rights Commission have been at achieving this critically important objective.

1.2 Review Process

Although we acknowledge and welcome the shift in the state government's approach to NCP, we do however remain concerned about a number of critical issues. These include the threshold issue of "onus of proof" that underpins NCP, how reviews are conducted and the adequacy of tools available to quantify costs and benefits.

A basic tenet of NCP is that competition is beneficial and only in instances where it can be clearly demonstrated that competition is "not in the public interest", are exemptions to be granted. In our opinion, particularly in the area of the provision of essential services by government, the opposite should apply. NCP should only be implemented in areas where it can be clearly demonstrated that competition is in the public interest, that is, "onus of proof" should be reversed. This concern has in part been addressed by the Beattie government's new approach to NCP reviews. The issue of how reviews are conducted is still of concern.

The QNU believe that government must always conduct NCP reviews. They are so important that the government must have confidence in and remain totally accountable for all such reviews. We are pleased that the review of the *Nursing Act 1992* has remained "in-house", however the same can not be said of the review of legislation that covers other health professionals. The consultancy firm Price Waterhouse Coopers is conducting this review. We have written to both the Premier and Queensland Health to express our concern about this issue as well as our concern about consistency of approach in reviews. The Premier has responded to our concerns regarding review processes, providing us with a copy of Queensland Treasury's Public Benefit Test Guidelines. The fundamental principle relating to the appropriateness of transference of responsibility for conducting reviews to corporations has however not been addressed to our satisfaction. We stress again that is our view that government, the elected representatives of the community, must be responsible for the total carriage of all such reviews. How it is determined whether reviews should be considered "minor" or "major" reviews is also of concern. The review of the *Nursing Act 1992* is considered a minor review but it is debateable whether this should be considered a major review (and therefore be the subject of more robust PBT assessment) given the significant potential for adverse health effects should barriers to practice nursing be weakened or removed. The determining factor appears in part to the availability and adequacy of tools to quantify the impact of change.

This brings us to our final issue of concern, whether sufficient robust tools currently exist to accurately estimate the economic and social impacts of any proposed regulatory change. Quite often such impacts are impossible to accurately quantify. This is particularly the case when assessing such impacts in a complex area such as health. We believe that when there is any doubt then the government must err on the side of caution and determine not to de-regulate. Econometric models alone can not predict all costs and benefits in a PBT assessment. The effect of the de-regulation of health professions on health outcomes and quality of care for the community is difficult to fully quantify. Such analysis has only fairly recently begun to occur in some areas. For example, an increasing body of US research is demonstrating *"that increasing levels of qualified nursing staff impact positively on broad indicators such as length of stay and mortality rates, as well as adverse events such as nosocomial infections."* (Chiarella and Crisp, p 6)

We have a number of other concerns that we wish to highlight about the review process to date. Firstly, we are concerned that only 27 submissions were made to the initial call for comment advertised in March 2000. We believe that this is an inadequate response and remain particularly concerned that the views of consumers may not have been adequately obtained to date. This second call for submissions is therefore very welcome. With respect to this though, we are concerned about the timing of this second part of the

process, given that further submissions were called for at the end of November 2001 and are due by 28 January 2002. We are concerned that the intervening Christmas period will result in a decreased response rate. The QNU, for example, has not been able to adequately consult with our membership due to the timeframe for comment. Other bodies and individuals (eg nurse academics) may also not be provided with adequate time for consideration of these issues given that many institutions "close down" for protracted periods over the Christmas break.

Another issue of concern is that the QNU and other organisations/bodies that represent the collective interests of nurses are not specifically mentioned in the list of key stakeholders contained on pages 5-6 of the discussion document. Individual clients, nurses and midwives, nursing support workers, the QNC, organisations that provide health services and employers are all mentioned but not the QNU (or other nursing organisations). This may be merely an oversight, but even so is of significance. As a representative of over 28,600 nurses in Queensland, the QNU is a significant stakeholder in this process. Given that NCP has been widely interpreted as being part of a wider ideological agenda that promotes the primacy of the marketplace and individual players in it at the expense of collective or social goals, this is a worrying oversight that may only serve to reinforce this perception.

For further explanation of our overriding issues of concern about the ideology underpinning NCP and its application to the health sector generally and nursing specifically also refer to section 1.1 above and our previous submission to this process.

2. Industry Profile of Nursing and Midwifery

2.1 Industry Profile of Nursing

2.1.1 The Role of Nurses

The International Council of Nurses defines a nurse in its constitution as "a person who has completed a program of basic nursing education and is qualified/authorised in his/her country to practice nursing" (ICN Constitution 1999, Article 6). The Australian Nursing Council Incorporated (ANCI) has published national competency standards for registered and enrolled nurses (ANCI, 1990 and 2000).

The ANCI defines the registered nurse as a first level nurse educated in degree level courses in universities. Registered nurses are licensed to practice nursing in a wide variety of health care settings and are registered to practice without supervision, assume accountability and responsibility for all their actions and aspects of care.

The Enrolled Nurse is defined by ANCI as a second level nurse who provides nursing care within the limits specified by education and the registering authorities' licence to practice. Enrolled Nurses work under the direction and supervision of registered nurses but retain responsibility for their own actions and remain accountable to the registered nurse for all delegated functions.

In relation to the role of unregulated workers who assist with nursing work, the ICN Position Statement *Assistive or Support Nursing Personnel* states:

"That the role, preparation, standards, and practice of assistive nursing personnel must be defined. monitored and directed by registered nurses."

It is important to stress that since the publication cited in your discussion paper the scope and breath of nursing practice has changed considerably. It is more essential that more recent publications on this issue are reviewed. For example, the ICN Position Statement on the Scope of Nursing Practice states that "Nurses' spheres of responsibility include giving direct care, supervising others, leading, managing, teaching, undertaking research and developing health policy for health care systems."

More recently, in 2001, Australia's first Nurse Practitioner was appointed in New South Wales. Other State and Territory Governments including Queensland are currently considering the implementation of this role in their respective jurisdictions.

Further exploration of this matter can be found in the papers produced as part of the current *National Review of Nursing Education*.

2.1.2 Composition of the Nursing Profession

It is of concern that in this section the unregulated nursing assistants are not recognised as contributing to nursing work. For a current exploration of the issues in this section an appropriate source would be the recently released *National Review of Nursing Education Discussion Paper*.

2.1.3 Education of Nurses

There are a number of concerns to the QNU in this section. Namely:

The narrow definition of nurse education contained in the paper.

That it has been almost a decade since the transfer of nurse education to the tertiary sector and there have been significant developments during this period that are not canvassed.

There is a significant public benefit associated with the transfer of nurse education to the tertiary sector that has not been acknowledged.

The importance of improved patient outcomes associated with the employment of qualified nurses (Chiarella and Crisp research paper) has not been adequately explored.

The evolving nature of educational articulation and recognition of prior learning has not been described.

Again, these issues are canvassed well in the current *National Review of Nursing Education* Research Papers.

2.2 Industry Profile of Midwives

2.2.1 The role of Midwives

Please refer to the QNU's previous submission. It is noted that the discussion paper does not indicate that the views of Queensland midwives were sought during the development of the paper. As the discussion paper suggests, there is currently considerable debate in relation to the regulation and education of midwifery practice.

3. Current Regulatory Arrangement

3.1 Objective

See comments in section 1.1 on the overriding objective of the act being consumer protection.

3.2 Rationale for the regulation of nursing and midwifery practice

The main rationale for the regulation of nursing and midwifery practice is the safety of the community. The issue of information asymmetry is intrinsic to health care "transactions", and this means that government intervention is required to ensure that minimum standards exist for nursing and midwifery education and practice. The QNC is a statutory body set up under legislation and is accountable to the parliament of Queensland via the Minister for Health. That such regulation is required for nursing and midwifery (and indeed the other health professions) is widely accepted. Certainly no arguments to the contrary have been raised in the discussion paper on the NCP review of the *Nursing Act 1992*. Until such time that such arguments are explicitly detailed then we believe that the need for the regulation of nursing and midwifery practice is beyond question.

This is not to say that the current regulatory mechanisms and practices should not be subject to scrutiny. Even though the QNU rejects the ideology underpinning the NCP of nursing, this review process has been useful as it has enabled us to reflect on current practices and has afforded us the opportunity to make recommendations to improve the current regulatory framework. It is also the case that our experience of opposing employers seeking to deregulate areas of health care via the substitution of regulated nursing personnel with currently unregulated care providers highlights current deficiencies in the existing regulating framework. Over recent years we have made a number of submissions to the QNC regarding the need to regulate the "third level" of nurse. Until such time that mechanisms are put in place to facilitate determinations about what constitutes nursing practice then the community will continue to be placed at risk by those service providers who knowingly employ non-nursing personnel to perform nursing tasks. The QNU will make recommendations about potential mechanisms for improving current arrangements in the options section of this paper.

The recent trend towards de-regulation (via substitution of nursing personnel) in health is of particular concern to the QNU. The link between the provision of quality health care and numbers of qualified and regulated nursing personnel is beginning to be clearly identified in overseas research. Research conducted in the USA that was cited in a recent paper by Claire M. Fagin titled *"When care becomes a burden: Diminishing Access to Adequate Nursing"* (p 10) highlights the dangers of a de-regulation agenda in health.

"Recent studies have shown that close to 20% of hospitalised patients have a serious adverse event during their hospital stay (Silber and Rosenbaum 1997; McGlynn, Naylor, Anderson, et al. 1994). RN- to-bed ratio was the single most important factor influencing hospitals' differing success rates in saving patients who experienced serious adverse events, according to Jeffrey Silber and his associates."

The findings of other recent US research may also be of interest to this inquiry. In June 2001 in Massachusetts a long awaited report of the *"Legislative Special Commission on Nursing and Nursing Practice"* was handed down. The overarching theme of this report was contained in the covering letter to the report by its authors Senator Robert S. Creedon Jr and Brockton Representative Christine E Canavan:

"Licensed nurses and the patients are inextricably linked. If the working conditions of the licensed nurse improve, direct patient care improves. If patients' concerns for quality care are met, the working conditions for the licensed nurses have been addressed. Their relationship is symbiotic."

This inquiry made 6 recommendations relating to improving the working conditions of nurses in that state, including proposing legislation to limit mandatory overtime and establish patient/staff guidelines based on patient acuity levels.

Other recent research from the USA, most notably a report from the Harvard School of Public Health titled *Nurse Staffing and Patient Outcomes in Hospitals*, highlights the important nexus between nurse staffing numbers and health outcomes for patients in some significant areas. To quote from the report (p xxiv) *"In the 11 state all patient analysis, strong and consistent relationships were found between nurse staffing and five patient outcomes, urinary tract infections, pneumonia, length of stay, upper gastro-intestinal bleeding and shock"*. This study also identified strong and consistent evidence of a link between nursing staffing numbers and of "failure to rescue" on major surgical patients. This ground-breaking report recommends developments in data collection systems that would enhance further research in this important area.

It is also important to highlight that the research conducted thus far has tended to concentrate on adverse outcomes if appropriately qualified nursing personnel are not employed, not the positive outcomes that are derived for registered and enrolled nurses practice. This deficit was highlighted in the Harvard School of Public Health study and a recommendation from this study and it recommended that attention be given to developing measures of positive clinical outcomes (Needlemam, Buerhaus, Mattke, Stewart and Zelevinsky, p 142).

For further information on other recent research in this important area please see the relevant papers produced as part of the current *National Review of Nursing Education*. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled *Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes*.

The levels of adverse events in Australian health care settings are a source of serious concern to the QNU. Many of these events can be attributed to "systems failures" rather than the failure of individual health practitioners. Various strategies that aim to decrease the incidence of adverse events in this country are in the process of being implemented. Of particular interest here are the activities of the *Australian Council for Safety and Quality in Health Care*, a body established under the auspices of the Australian Health Ministers Forum. Although there is reluctance on the part of some health professionals to be involved in the activities of the Council, the QNU and other nursing organisations welcomes this long overdue initiative. We believe that it is critically important that nurses are actively involved in driving the Council's agenda at the health facility level. After all, nurses act as patient advocates on behalf of individual patients every day of their working life. Involvement in the agenda of the *Australian Council for Quality and Safety in Health Care* is for us a logical extension of this advocacy role to a systemic/collective level. Nursing must therefore be an integral part of the agenda to improve health outcomes for the whole community.

The QNU also wishes to make brief comment on some of the assertions contained in the discussion paper. An assertion is contained in the first paragraph that "restrictions on who can practice nursing or midwifery may lead to increased prices for nursing services and a reduction in choice of service providers available to consumers"? Where is the evidence to support this very strong assertion? It certainly isn't contained in the discussion document, rather the ideology of competition has merely been blindly accepted.

On another point, an assertion is made that shortages of qualified nurses may lead to increased prices, but there is no evidence that regulation has contributed to this. The current nursing shortages have not resulted from regulation and have not been "manufactured" by the profession. The reasons for these shortages are complex, but in our view are in large part can be attributed to the systemic and longstanding undervaluing of nurses and nursing. A fundamental logical inconsistency is apparent to the QNU relating to the issue of "market forces". Market forces are accepted when they drive prices down, but railed against

when prices are driven up. We watch with interest what determination the ACCC will make with respect to an application by the Victorian government (Health Purchasing Victoria) for exemption from prosecution under the *Trade Practices Act* with respect to their plan to limit payment to agency nurses employed in public hospitals in Melbourne and Geelong.

With regards to assertions contained in the second paragraph in this section, there are a number of issues that need to be addressed. Firstly, the use of the word "restrictions" in the first sentence is overly narrow. There are significant reasons for maintaining "regulation" of nursing – regulation goes beyond restrictions on practices and encompasses issues such as standards for nursing education. Secondly, the over-emphasis on "treatment" in the second part of this paragraph is also of concern. Assessment, planning, implementation and evaluation (ie the nursing process) is a broader concept that goes beyond the narrow confines of treatment. (This demonstrates a fundamental misunderstanding of the nursing process - eg also relates to the promotion of health and well being.)

The table on page 12 that summarises the "main heath risks" for consumers is woefully inadequate and understates the potential magnitude of risks associated with lack of regulation or inadequate regulation. That is it could result in death or serious injury.

The way in which the problem "information asymmetry" is presented on page 12 is of particular concern. The definition in the footnotes, though brief, is correct. The conclusions that are drawn about information asymmetry in the body of the text are misleading and have missed the point about information asymmetry. Regulation of the professions exists because of information asymmetry. The codification of expectations about standards and scope of nursing practice, necessary educational qualifications and ethical standards are required to protect the consumer. Many consumers will never be able to objectively assess the relevant standards of practice of nurses, midwives and other professionals. Regulation of the professions gives the public confidence that there are minimum standards that must be met to practice. Governments intervene to regulate professions for this purpose. If it can be demonstrated that the regulatory framework is not meeting its objectives (and it has not been in this instance – not in the paper at least) then that is an issue that requires urgent attention via the strengthening of regulatory provisions. It has not been demonstrated how "the lack of information may create incentives to decrease the quality of nursing services". Such a serious assertion must be challenged and demand explanation and further examination. Indeed, the provision of information to and advocacy for patients is central to the role of the nurse. The issue of information asymmetry is critically important and needs to be addressed, but it will not be addressed by the application of competition in health care. It must be addressed via maximising consumer education of health services, treatment options and rights. But no matter how much information of this nature is provided knowledge imbalance will still exist. This could relate to matters such as diagnosis (including differential diagnosis), disease aetiology and progression, treatment options and prognosis. Such information in inherent in the attainment of specialised knowledge. Even health professionals in one specialty area will experience information asymmetry in comparison to colleagues in another specialist field. This is the nature of professional knowledge.

It is disappointing that this section of the discussion document on NCP review of *Nursing Act 1992* did not make mention of international work by Styles and Affara on a framework for regulation of nursing. This framework was proposed in their 1997 work on behalf of the International Council of Nurses titled *ICN on Regulation Towards 21st Century Model* (page 17). This highlights the need for a nationally (and indeed internationally) consistent approach to nurse regulation and provides a 12-point schema for the assessment of the adequacy of current regulatory regimes.

These 12 principles are:

1. purposefulness
2. relevance
3. definition
4. professional ultimacy
5. multiple interests and responsibilities
6. representational balance
7. optimacy
8. flexibility
9. efficiency and congruence

10. universality

11. fairness and

12. inter-professional equality and compatibility

Although this framework represents the “ideal” and may also be seen as not being appropriate in all settings (eg may not be appropriate in all cultures), it provides an interesting debating point and potentially an aspirational framework for nursing regulation.

The *National Review of Nursing Education* has prepared a detailed research paper on the regulation of nurses in Australia that may be of interest to this review.

3.3 Background to, and administration of, the Anti-competitive provisions

3.3.1 Scope of Nursing Practice

With regards to this section, we wish to have it noted that the list of nurses roles on page 13 that is provided from the NHMRC 1991 document, is in our view it is woefully out of date. There has been significant advancement in the scope of nursing practice in the last decade. For example, the roles of advanced practice nurses such as Nurse Practitioners are developing. More recent views on this topic can be found in the research documents arising from the current *National Review of Nursing Education*.

We particularly wish to comment on the paragraph beneath the dot points in this section that refers to difficulty experienced in defining the scope of nursing practice. The quote from the UK regarding nurses struggling to define its character is a misleading and unsubstantiated assertion. When you go to the actual article that is quoted (in *Nursing Times*) you find that the statement quoted in the discussion paper is the lead sentence of the article, but this assertion is sourced to another 1996 article in the *British Medical Journal*. This begs the question, who is confused about the emerging role of nurses, doctors or nurses. We reject the assertion that there is confusion of roles amongst nurses – the situation is evolving but decisions about the advancing scope of practice are rooted in attaining the necessary knowledge and skills before the scope of practice is advanced.

The comment in this section paper on the non-prescriptive approach of the QNC to scope of practice issues must be seen in the context of the powers of the QNC being conferred through legislation and that the QNC is ultimately accountable to parliament through the Minister for Health. Can it be demonstrated that these accountability mechanisms are wanting?

The discussion paper makes an unsubstantiated assertion that nurses are now undertaking roles that were previously the domain of other health professionals. In our view this demonstrates a limited knowledge of the history and development of nursing and requires substantiation.

On the general issue of the regulation of the scope of nursing practice, we wish to place on the record our strong and long held view that those currently unregulated care providers that are undertaking nursing practice must in some way be regulated by the QNC. This includes AINs (howsoever termed) and ATSI health workers. If these health workers are not regulated this will, in our view, merely aid the substitution/ de-regulation agenda that is currently gaining ascendancy. This is a critically important issue, as such regulation would better ensure standards of patient or resident care. Just because someone is a client in an aged care facility or a remote indigenous community should never mean that they are not entitled to accountability for the standard of health care that is being provided to them.

The Australian Health Minister’s Advisory Committee (AHMAC) is currently investigating the appropriateness of establishing registration for ATSI health workers, a move that is welcomed by the QNU. (Cultural appropriateness is an important issue that must be addressed in the delivery of health services in indigenous communities but this must be balanced with the rights of these communities to expect the same level of regulation as non-indigenous clients. The same is true for the argument about aged care being de-institutionalised and made “home like”. These arguments can merely mask a deregulation/substitution agenda, which enable employers to utilise unregulated and hence less costly care providers.)

With respect to the matter of the supervision of ATSI health workers, we wonder what is the QNC’s view of the assertion on p 17 that most (though not all) ATSI health workers report to a registered nurse.

We also refer to the section on QNC prosecutions since 1996 - This section has failed to address the issue of statistics on the number of investigations by the QNC on practice issue complaints. This is a critically important component of regulation by the QNC. The QNC does not merely deal with those who “hold themselves out to be nurses” or have failed to maintain registration. Another critical component on regulation is ensuring the maintenance of acceptable standards of nursing practice. It is important to also

assess the statistics from the QNC regarding investigation of complaints relating to professional conduct. The following tables represent a breakdown of the types and source of complaints made since 1996: (Source *QNC Annual Report 2001*.)

Types of Complaints to QNC 1996 –2001

Type of Complaint	1996	1997	1998	1999	2000	2001
Incompetence	1	7	2	9	4	22
Bad Health & Conduct	3	7	4	5	5	6
Conduct	8	28	29	29	36	44
Health Concern	8	18	30	19	54	43
Boundary Violation	7	3	1	2	5	3
Whole Agency			3			7
Other	20	5	10	1	8	10
TOTAL	**47**	**68**	**79**	**70**	**112**	**135**

Source of Complaints

Source	1996	1997	1998	1999	2000	2001
Consumer	3	12	10	4	5	11
Chief Health Officer/ Environmental Health	5	1	2	1	5	1
Director of Nursing	20	26	26	31	48	57
Employer/District Manager	3	5	9	11	25	23
Health Rights Commissioner	6	4	4	4	3	5
Other Health Professional	1	2	2	3	3	10
Other Including newspaper	5	9	20	12	16	20
Peer/Nurse	4	9	6	4	7	8
TOTAL	**47**	**68**	**79**	**70**	**112**	**136**

The assessment of nurse educational standards and course curriculum and the setting of policies and guidelines must also be considered as an essential part of the regulatory function of the QNC. The review of the number of prosecutions and who is "targeted" in these processes is of course an important part of the review of how the QNC has utilised its regulatory powers. But to look at the number of prosecutions alone, in the absence of the other regulatory functions of the QNC paints a very narrow picture of the broad regulatory role and function of the Council. We would strongly urge that a broader assessment of the regulation by the QNC be undertaken as part of this review as this gives a better understanding of the nature and extent of consumer protection inherent in the Council's processes.

The assertion contained in the first paragraph on page 18 that the current wording of the act makes it difficult for the public to adequately understand what constitutes nursing practice applies equally to all professions. The scope of practice of all professions is inherently difficult to describe to the public because this is based on a body of expert knowledge that is not possible to be contained in legislation. This is why peer management is central to the operation of professions.

With respect to the assertion that "until recently" the QNC has chosen not to prosecute unqualified workers, two questions have not been asked. Firstly, how many unqualified workers have been prosecuted recently and secondly have such prosecutions only commenced recently?

The paper appears to be implying that QNC's approach to date appears to have concentrated on the pursuit of the alleged misconduct of individual practitioners rather than addressing more complex systemic issues. Although we acknowledge that a critically component of the QNC's role includes ensuring the safe practice of individual nurses, we would say that this occurs in a context and this context is not always acknowledged.

3.3.2 The Scope of Midwifery Practice

We wish to again highlight to this review that some useful materials regarding the scope of midwifery practice can be found in the research papers produced as part of the current National Review of Nursing Education.

3.4 Approaches in other jurisdictions

For further analysis on the approach to regulation in other jurisdictions please see the relevant papers produced as part of the current National Review of Nursing Education. Of particular relevance are the discussion paper and research paper by Chiarella and Crisp titled Review of Nurse Regulation: Standards for Nursing Care and relationships between Skill Management and Patient Outcomes

4. Options

4.1 Options for Nursing

4.1.1 Option 1 - Title Only

Not supported.

4.1.2 Option 2 - Title and Core Practice Restriction

Not supported.

4.1.3 Option 3 – Title and Broad Practice Restriction

Option 3 A

Not preferred – needs to be extended. (See Option 3 C below.)

Option 3B

Not preferred – needs to be extended. (See Option 3 C below.)

Option 3 C – Title and Broad Practice Restriction

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must contain the necessary exemptions for other regulated health professionals and those with “Nursing” in their position title (eg Assistants in Nursing and Nursing Students) who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council’s powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

4.2 Options for Midwives

4.2.1 Option A – Title Only

Not supported.

4.2.2 Option B Title and Core Practice Restriction

Not preferred. A Title and Core Practice Restriction is Supported, but with the core practices that are restricted must be expanded. See Option C below.

Option C Title and (Broader) Core Practice Restriction

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes “core” midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

(a) *Antenatal Care;*

(b) *Labour (all stages);*

(c) *Postnatal care of the mother;*

(d) *Neonatal care; and*

(e) *Education and Research.*

Specific Questions to Be Answered as Outlined in 4.0 Options (p 23)

Which are your preferred options for nursing and midwifery?

Nursing: Our preferred option is new option 3c as outlined above as:

Our preferred option would be an amalgamation of options 3A and 3B, with some additional conditions. Our preference is for the maintenance of the current nursing service and practice restrictions contained in the Act. Our preferred option (3 C) must contain the necessary exemptions for other regulated health professionals and those with "Nursing" in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained. Other amendments to the act would also be required to strengthen the Queensland Nursing Council's powers to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

We would not support a definition of nursing practice being inserted in the Act as this would be too restrictive. We do however accept that there is a need for a better mechanism that facilitates the definition of nursing practice being investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

Midwifery: – Our preferred option for midwifery is a new C option, a title and (broader) core practice restriction as outline above as:

We believe that a title and broader core practice restriction is appropriate for Midwifery practice. The definition of what constitutes "core" midwifery practice should be expanded to incorporate the definition of midwifery practice that was included in our original submission. Namely:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

(a) *Antenatal Care;*

(b) *Labour (all stages);*

(c) *Postnatal care of the mother;*

(d) *Neonatal care; and*

(e) *Education and Research.*

What are the reasons for your preferred options?

Nursing -In our view title restriction alone is insufficient to protect the community as it fails to regulate actual nursing practice –ie it ignores those who are undertaking nursing practice under another title. There is a need to regulate unqualified practitioners who are undertaking nursing practice given that the overriding rationale for act is consumer protection. Currently there is a substitution/de-regulation agenda in some areas (eg aged care) that is facilitated by deficiencies in the act and/or limited action by QNC against employers engaged in such activities.

We accept there is a need for better mechanisms that would facilitate the definition of nursing practice, but believe that it would be too complex and restrictive to construe a definition of nursing practice for legislative purposes.

A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

Midwifery – We need a broader definition of midwifery practice because there are risks to the consumer at all stages of the confinement not just at the time of Labour. The title of midwife needs to be protected to ensure that persons who are not appropriately qualified do not engage in practices that may endanger a mother or foetus/infant. A combination of title and (broader) core practice restriction is supported for to ensure that consumer protection is maximised.

Which options do you consider workable or feasible?

The preferred options stated above are the only ones that we believe are workable and feasible.

What costs and benefits are there for each option, in relation to your activities/operations and that of other stakeholders?

We have attempted to quantify the costs and benefits associated with each of the options but have found that this is impossible to do in a meaningful way. We can talk broadly about the issues that need to be considered, but when it comes down to quantifying actual costs and benefits of each option, we question the validity of such an analysis. For example, it is difficult enough identifying opportunity costs associated with each option let alone attempting to determine the full range of possible costs and benefits.

The advantages and disadvantages contained in the discussion paper are acknowledged as being worthy of consideration.

Where possible, can you estimate the monetary value of the cost or benefit?

Quantification of costs in dollar terms is extremely difficult given the complexity of the health sector. The main costs would relate to decreased quality of care and hence patient outcomes (eg increase in adverse events, increased length of stay etc) and also increased litigation. Indeed we believe that it is very dangerous and indeed inappropriate to attempt to quantify costs in dollar terms in the absence of a rigorous and agreed methodology for quantifying costs.

Which options, for both nursing and midwifery, do you consider best meets the objectives of the legislation?

The options that we have stated are preferred – see above

In relation to the options for nursing:

(a) should the title "nurse" , and derivatives such as assistant in nursing, be restricted to persons authorised under the Act; and

Yes, we have made submissions to this effect for some time now. This is currently a serious deficiency in the Act. Any person, howsoever termed, undertaking nursing practice needs to be regulated.

(b) which other titles, if any, should be restricted to only persons authorised under the Act?

We currently can not identify any other titles that need to be authorised under the act so long as better mechanisms are available to facilitate the determination of whether someone is undertaking nursing practice. (Once determinations are made then these could, for example, be made publicly available on the Internet and in other forms to facilitate public awareness of what constitutes nursing practice. Consumer input into such determinations would also be required so as to ensure that consumer expectations are taken into consideration.) This would ensure that those engaged in nursing practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

In relation to options for midwifery:

(a) should the title "midwife" be restricted to persons authorised under the Act; and

Yes.

(b) which other titles, if any, should be restricted to only persons authorised under the Act?

We currently can not identify any other titles that need to be authorised under the Act. So long as the definition of midwifery practice is extended in line with our definition and there are mechanisms are available to facilitate the determination of whether activities constitute midwifery practice then this should be sufficient. This would ensure that those engaged in midwifery practice, howsoever termed, would be picked up. If you start identify specific nomenclature in the act new ones are bound to arise which will not be covered because they are not specified in the act. The key is to regulate nursing practice no matter who is undertaking it.

In relation to option 3B for nursing, how should "nursing practice" be defined in the Act?

This matter is complex and needs further urgent consideration. It may not be possible to establish a clear definition of nursing practice that is suitable for legislative purposes. This is not to say that mechanisms that facilitate such definitions being made in an appropriate and timely manner can not be given effect under the act. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

In relation to option B for Midwifery, is the proposed core practice adequate to ensure that only midwives can practice midwifery activities that carry significant risks if performed by unqualified persons?

As stated above, we believe that the definition of midwifery practice needs to be broader to ensure consumer safety. Our suggestion is as follows:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

(a) *Antenatal Care;*

(b) *Labour (all stages);*

(c) *Postnatal care of the mother;*

(d) *Neonatal care; and*

(e) *Education and Research.*

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Summary of QNU Recommendations

Further to the recommendations made in our 2001 submission to this review, the QNU makes the following recommendations:

Recommendation 1: That as part of this review process public input be sought on the threshold issue of the appropriateness of subjecting services such as health (and in this instance nursing) to the application of National Competition Policy.

Recommendation 2: That the Public Benefit Test assessment criteria include those that measure the impact on the Government's Priority Outcomes as well as specific criteria to measure health outcomes.

Recommendation 3: That legislative amendments be made to the Nursing Act 1992 to require the Queensland Nursing Council to regulate those currently unregulated health care providers who are undertaking nursing practice. (With the proviso that other regulated health providers are exempt from this provision so long as they are working within their profession's scope of practice.)

Recommendation 4: That mechanisms that facilitate the definition of nursing practice be investigated as a matter of urgency. Given the evolving nature of nursing practice, such a mechanism could take the form of an expert body of nurses formally constituted under the legislation to enable the profession to define nursing practice as the need arises. The composition of such a body should be able to be extended as required when specialist-nursing knowledge is required and should contain at least one consumer representative.

Recommendation 5: That legislative amendments be made to the Nursing Act 1992 that protect the use of title of nurse and midwife. Further to this, that a title exemption also be given to those with the word "Nursing" in their title (eg Assistant in Nursing" or "Nursing Student") who are working under the direct and indirect supervision of a Registered Nurse.

Recommendation 6: That the current restrictions relating to the provision of a nursing service and nursing practice contained in the Nursing Act 1992 be retained. (Note: Option 3b does not include the nursing service component.)

Recommendation 7: That the current legislative provisions of the Nursing Act 1992 be strengthened to enable the Queensland Nursing Council to take action against employers who either: instruct regulated employees to engage in conduct that may threaten their licence to practice or engage unregulated personnel to undertake nursing practice.

Recommendation 8: That a Title and Broad Practice restriction be adopted (a combination of Options 3A and 3B) that: maintains the current nursing service and practice restrictions. This option (3 C) must contain the necessary exemptions for other regulated health professionals and those with "Nursing" in their position title who are acting under the direct or indirect supervision of a Registered Nurse. Further to this, the existing penalty provisions detailed in the act should be maintained.

Recommendation 9: That the *Nursing Act 1992* be amended to include the following definition of midwifery practice:

Midwifery practice is the care of a client from pre-conception to a point six (6) weeks post delivery of the child/children. It incorporates but is not limited to: -

(a) Antenatal Care;

(b) Labour (all stages);

(c) Postnatal care of the mother;

(d) Neonatal care; and

(f) Education and Research.

Recommendation 10: That a Title and Core Practice restriction be adopted for Midwifery and that the definition of the Core Practice include activities outlined in recommendation 9 above.