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THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Health Legislation (Waiting List Integrity) Amendment Bill 2015

Submission to the

Health and Ambulance Services Committee

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Introduction

The Queensland Nurses' Union (QNU) thanks the Health and Ambulance Service Committee (the Committee) for the opportunity to make a submission to the inquiry into the *Health Legislation (Waiting List Integrity) Amendment Bill 2015* (the bill).

Nurses and midwives for 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 and midwifery 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 52,000 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.

Wait Time Guarantee

In November, 2014, the then Health minister announced that from 1 February 2015 all elective surgery would be carried out within the following nationally-recommended times:

- Urgent (Category 1): Surgery recommended within 30 days of being added to the wait list as the condition could get worse or become an emergency;
- Semi-urgent (Category 2): Surgery recommended within 90 days of being added to the wait list as the condition is causing pain or disability but unlikely to become an emergency;
- Non-urgent (Category 3): Surgery recommended within 365 days of being added to the wait list as the condition is causing minimal pain or disability.

Under the Wait Time Guarantee:

- if the local Hospital and Health Service could not provide treatment within the medically recommended time, the patient would be offered the next available appointment in a public or private hospital elsewhere in the state at no cost;
- patients would not have to pay for any travel or accommodation costs, if they were treated more than 50 kilometers from their original hospital;
- if treatment could not be provided in the original hospital within the medically recommended time the patient had to give consent to be treated in another public/private hospital.

Eligibility criteria included if the patient was:

- medically ready for care;
- able to provide proof of residency (75 points of original/certified identification is required to prove residency);
- a Medicare card holder;
- assessed by a medical specialist as being able to benefit from surgery;
- willing to consent to surgery;
- personally ready for care.

Ineligibility criteria included if the patient:

- elected to be treated in a private facility;
- opted out of surgery for personal reasons;
- needed longer wait time for specific reasons;
- was awaiting treatment that falls under the medically recommended exceptions;
- lived outside Queensland.

There were three medically recommended exceptions why some elective surgery was not covered by the wait list guarantee:

- Surgery is not covered by Medicare or the government has determined these operations are not publicly funded because they are either medical unnecessary, are under trial, do not represent value for the limited taxpayers funds or there is not enough evidence to show the benefits of surgery outweigh the risks;
- There are not enough surgeons with the specialised skills in Queensland. Patients may need to wait longer for surgery in areas such as breast reconstruction, complex upper and lower limb surgery and bariatric surgery (the list of operations not covered would be reviewed and updated every 6 months);
- An organs or tissue donation is required for the surgery.

In Australia, lowering waiting times for elective surgery has been a policy focus over the last two decades. Waiting time guarantees have become the most common and effective policy tool to tackle long waiting times, however, according to Siciliani et al. (2013) they are only effective if enforced.

Initially, the focus at the national level was on subsidising private health insurance with the aim of shifting demand from public to private hospitals. More recently, policies have shifted to directly expanding public hospital capacity and providing financial incentives to states for achieving lower waiting times. Despite these expensive efforts, waiting times barely changed, with the median even increasing slightly (Johar et al., 2013).

There are large variations in waiting times across states. There is some evidence that state-based programmes are more effective than national ones, but their impacts have been short-lived. Several features of the current system for managing waiting lists may contribute to long waiting times, including the wide discretion given to specialists in assigning urgency to patients on the waiting list (Siciliani, et al., 2013).

To enforce waiting time guarantees, waiting times need to be measured systematically. Emerging best practice includes measuring the waiting time of patients and the total patient journey beginning in primary care e.g. United Kingdom measures waiting time from GP referral to hospital treatment (Siciliani, et al., 2013).

The QNU has concerns that the previous LNP government's introduction of the Wait Time Guarantee just prior to the last state election, coupled with the significant spending to promote it, was motivated more by political spin than public interest. It is also somewhat disingenuous to claim the LNP's efficient management enabled this initiative when the prior Labor government's massive investment in health infrastructure increased capacity for elective surgery.

In our assessment of the scheme there are a number of exclusions that have enabled a selective relabelling of the existing situation into a neatly marketed product that includes:

- The Wait time guarantee is measured from the time the patient is added to the elective (non-emergency) surgery wait list until the time they receive surgery. This may not happen on the day the specialist confirms surgery and does not include outpatient wait time;
- Diagnostic, medical and obstetrics procedures are not covered by the wait time guarantee e.g. endoscopies, MRIs, CT scans, x-rays, biopsies, stress echoes;
- A patient can delay surgery for personal reasons but can be removed from the wait list if they delay beyond the maximum limits;
- There is potential for numerous system manipulations or workarounds to occur in relation to the application of the eligibility criteria. For example, the absence of standardised clinical prioritisation tools could lead to variation in patient categorisation and general data cleansing practices could influence the reporting outcome;
- To meet the eligibility criteria for the wait list guarantee, a medical specialist must accept a patient for surgery. However, there are currently no waitlist guarantees in outpatient departments to ensure adequate access to a medical specialist in the first place;
- GPs have increased responsibility for providing the appropriate medications and organising of tests, allied health and other non-specialist treatments prior to referral - GPs may not be sufficiently informed and/or prepared for what is required in this new initiative;

- Similarly, the wait time guarantee is dependent on the availability of test results though there are no guarantees on the wait times for diagnostics procedures like endoscopies;
- There are numerous variables associated with the wait time guarantee that can affect the length of time a patient waits such as test wait times, outpatient wait times, surgery type, availability of specialist skill and administration processes;
- Evaluation of the variables relating to increased wait times could be used to shift blame away from deficiencies in the wait list guarantee – for example in the case of GP services, any inadequacies could be linked with the performance of the Commonwealth;
- There is no mention of travel/accommodation support for carers or the administration process that would be involved if patients accepted treatment in another hospital;
- The wait time guarantee gives incentive to hospitals to manage their own service demand otherwise be 'out of pocket' for the patient's travel and accommodation costs, but aside from this there are no other economic enforcers.

These factors suggest the waiting time guarantee has numerous limitations. Of broader concern however, is the introduction of a bill into the parliament to enable reporting on just one function of the public health system when there are so many other indicators of performance that fail to be published. The sixteen Hospital and Health Services (HHS) across Queensland have a range of obligations for reporting data driven principally through Service Agreements between the HHS and the Department of Health. In addition, there are other reporting drivers such as legislation, policy or inter-governmental requirements.

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The Bill establishes the Health Ombudsman as the independent reviewer of clinical waiting times in the public health system through a quarterly reporting regime of wait time data. While we support greater transparency in the publication of health performance information, we contend that the Health Ombudsman's main objective should be to guarantee safety and quality. We are not convinced it is appropriate to assign an auditing and reporting function to this Office when its main responsibilities are to receive, investigate and act on complaints about health services and providers (Office of the Health Ombudsman, 2015).

Public data reporting provides competitive incentives for healthcare providers to improve their accountability and clinical performance (Henke, Kelsey & Whately, 2011; McKinsey &

Company, 2013). To this end, we call on the government to establish a Bureau of Health Information, similar to that which exists in NSW, which will be responsible for:

- performance of the Qld public health system;
- providing an annual report to the Minister and Parliament on the performance of the Qld public health system;
- publishing reports benchmarking the performance of the Qld public health system with comparable health systems;
- establishing and maintaining a website providing information and analysis on the performance of the Qld public health system, including tools for data analysis;
- developing reports and tools to enable analysis of the performance of health services, clinical units and clinical teams across the Qld public health system;
- advising Qld Health on the quality of existing data sets and the development of enhanced information analysis and reporting to support performance reporting to clinicians, the community and Parliament;
- undertaking and/or commission research to support the performance by the Bureau of its functions;
- liaising with other bodies and organisations undertaking reporting on the performance of the health systems in Australia;
- providing advice to the Minister for Health on issues arising out of its function.[1]

In the interim, the Queensland Audit Office (QAO) may be a suitable reporting alternative. The QAO conducts financial and performance audits of public sector entities to assess how effectively, efficiently and economically their objectives are being met (QAO, 2015). This office is well placed to gather, audit and report on data, independent of the health system.

We ask the Committee to consider this Bill in light of the recent publication of the *Hunter Review* (Hunter, 2015) which recommends significant changes to Queensland Health's structure and governance. The *Hunter Review* acknowledged the need for improved data integrity to enable sharing of information across the Department of Health and HHSs, and greater accountability and transparency so all stakeholders can have faith in the accuracy of information. To this end, the *Hunter Review* recommended the creation of a Health Statistics and Data Integrity Branch which may be a suitable source for collecting and reporting on waiting time data. The review also recommended the re-establishment of the Patient Safety and Quality Improvement Service as a Branch within the proposed Clinical Excellence Division in order to enhance patient safety and service quality (Hunter, 2015). We welcome this renewed focus.

[1] Adapted from Bureau of Health Information (2015).

The QNU continues to promote the introduction of a 'quality care guarantee' rather than a 'waiting time guarantee' by mandating and enforcing the participation of public, private and aged care sectors in reporting minimum nursing/midwifery data sets that monitor nurse/midwife ratios, skill mix levels and quality outcomes across Queensland. This may be a broader agenda, but one that is ultimately more valuable to the community.

Conclusion

Waiting time is just one facet of the overall functioning of the health system, but as the LNP has demonstrated, it can be also become a commodity that can be quantified, neatly parcelled into a political manifesto and marketed to the public. Repackaging and rebranding elective surgery into a 'guarantee' served the political purposes of the previous government at the lead up to a highly contested state election.

Perhaps polling indicated to the LNP that the waiting time guarantee was a potential political winner and for this reason they continue to be unwilling to abandon it. Unfortunately, the priority given to the scheme reflects an emphasis on acute care at the expense of upfront investment in primary care. This may advantage some in the short term, but in the long term disadvantage many.

Recommendation

The QNU recommends the Committee:

- considers reassigning the audit and reporting requiring to the QAO pending establishment of a Bureau of Health Information;
- takes into account the revised structure and governance arrangements contained in the *Hunter Review* which recommended the creation of a Health Statistics and Data Integrity Branch.

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