Australian Nursing & Midwifery Federation

8 December 2015

Dr Kathleen Dermody
Committee Secretary
Senate Economics Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Canberra Office
Unit 3, or PO Box 4239
28 Eyre Street
Kingston ACT 2604
Australia

T +612 6232 6533
F +612 6232 6610
E anmfcanberra@anmf.org.au
W www.anmf.org.au

Melbourne Office
Level 1, 365 Queen Street
Melbourne VIC 3000
Australia

T +613 9602 8500
F +613 9602 8567
E anmfmelbourne@anmf.org.au
W www.anmf.org.au

ANMF Journals
Australian Nursing and Midwifery Journal
E anmj@anmf.org.au

Australian Journal of Advanced Nursing
E ajan@anmf.org.au

ABN 41 816 898 298

Dear Ms Dermody

Inquiry into economic security for women in retirement

Thank you for the opportunity to provide further feedback to the Inquiry into *Economic security of women in retirement*. The Australian Nursing and Midwifery Federation (ANMF) committed to providing further information on three particular matters during our appearance before the Senate Economics Committee on 19 October 2015.

The ANMF submits information on those matters as outlined in the attached appendices:

Appendix A
The ANMF's recommended model for fairer redistribution of superannuation tax concessions.

Appendix B
The ANMF's recommended strategies and policy directions for achieving savings within the health system.

Appendix C
Further details on the selected earnings and employment data on nurses, midwives and carers.

Thank you for your consideration of these matters. Please do not hesitate to contact this office if you have any further questions.

Yours sincerely

Annie Butler
Assistant Federal Secretary

The industrial and professional organisation for Nurses, Midwives and Assistants in Nursing in Australia

APPENDIX A

The ANMF's recommended model for fairer redistribution of superannuation tax concessions

Attached is an extract from Industry Super Australia's submission[1] to the Inquiry into Economic security of women in retirement which the ANMF recommends as an appropriate model to rebalance superannuation tax concessions to ensure they are distributed more equitably.

[1] Industry Super Australia. *Inquiry into Economic security for women in retirement: ISA submission*. ISA, 2015. At http://www.industrysuperaustralia.com/assets/Submission/Inquiry-into-economic-security-of-women-in-retirement-ISA-Submission.pdf

3.3 Structural Reforms

3.3.1 Rebalance superannuation tax concessions to ensure they are distributed more equitably

As detailed above, currently tax concessions are poorly targeted. The bulk of tax concessions support the retirement incomes and residual estates of those who are not receiving the Age Pension and who would have a comfortable level of retirement income anyway.

On average men receive twice as much support as women through super tax concessions.

Rebalancing tax concessions in favour of low to middle income earners will not only ensure that tax concessions are better targeted to improve economic security for women, but will also improve the efficiency of the system, reducing future fiscal outlays on the Age Pension.

Consideration of paring back the generosity of outlays on superannuation tax concessions provides an unparalleled opportunity to repair the key structural drivers of inequity and inefficiency in Australia's superannuation settings.

Rebalancing tax concessions to improve outcomes for women is both an economic and political imperative.

ISA has developed a package of indicative reforms to rebalance superannuation tax concessions, to ensure they are more effective, efficient, sustainable and equitable.

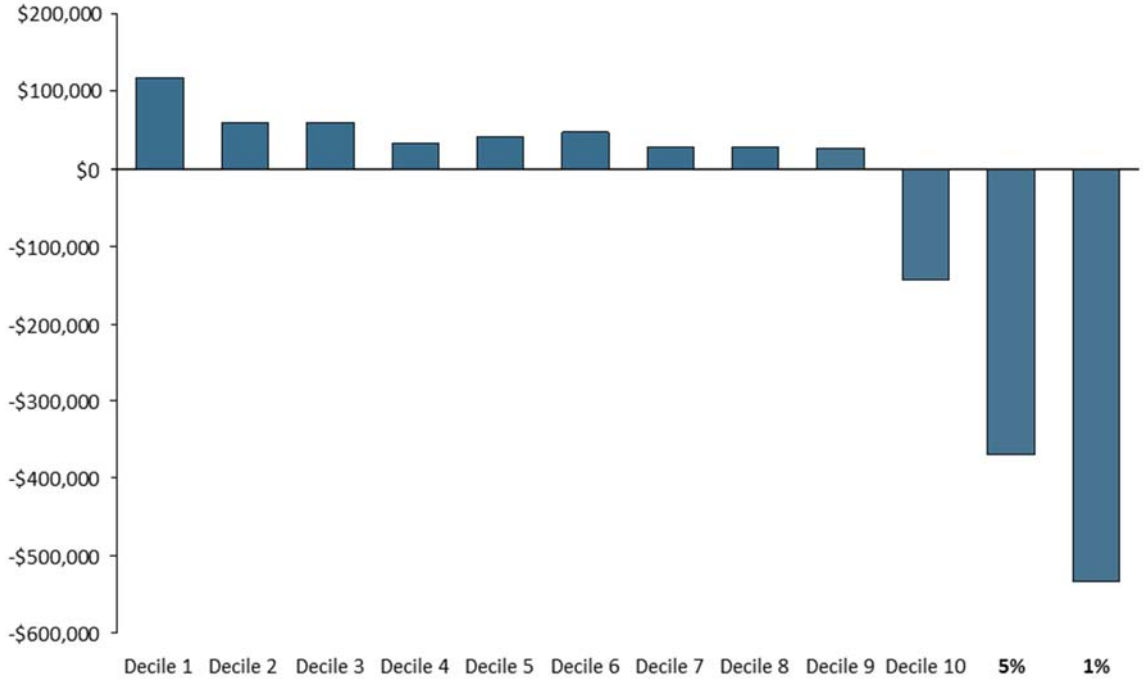
Table 8 – Proposed reforms to tax concessions

No	Area of reform	Description
1	Superannuation contributions tax reform	All superannuation contributions are taxed at marginal rates and eligible for a 25 per cent offset on the gross contribution, which is capped at $7,500 p.a. and paid to the fund.
2	Contributions cap	Contributions capped at $50,000 p.a., with additional "catch up" contributions in limited circumstances.
3	Superannuation earnings tax reform	Accumulation and retirement earnings taxed at 15 per cent per year. All tax rebated for earnings below $50,000 p.a. in the retirement phase.

While superannuation tax concessions should be recalibrated, it remains the case that all mandatory super savings should receive a tax concession benefit to compensate for the compulsory shift away from current consumption.

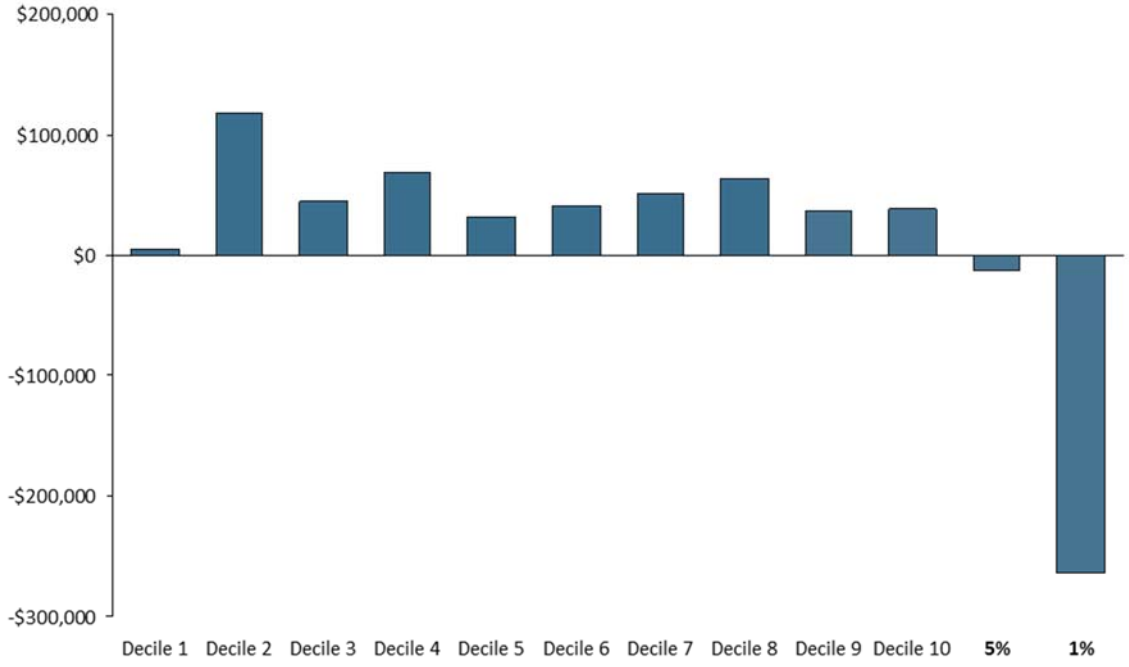
Figure 19 shows the change to the level and distribution of super tax concessions after implementation of the indicative package. The tax concessions are reduced primarily due to the reduction in the amount that can be contributed into superannuation, and the addition of a tax on earnings above $50,000 per annum in the retirement phases, and not from a reduction in the concession on contributions. Indeed, the indicative proposal provides a 25 per cent tax offset on contributions, which is larger than the 15 per cent net concession on contributions by individuals above the $300,000 threshold under Division 293. The 15 per cent tax on earnings above $50,000 extended into the retirement phase also has a modest effect.

Figure 19 – Change in life time tax concessions, single males, retiring in 2055



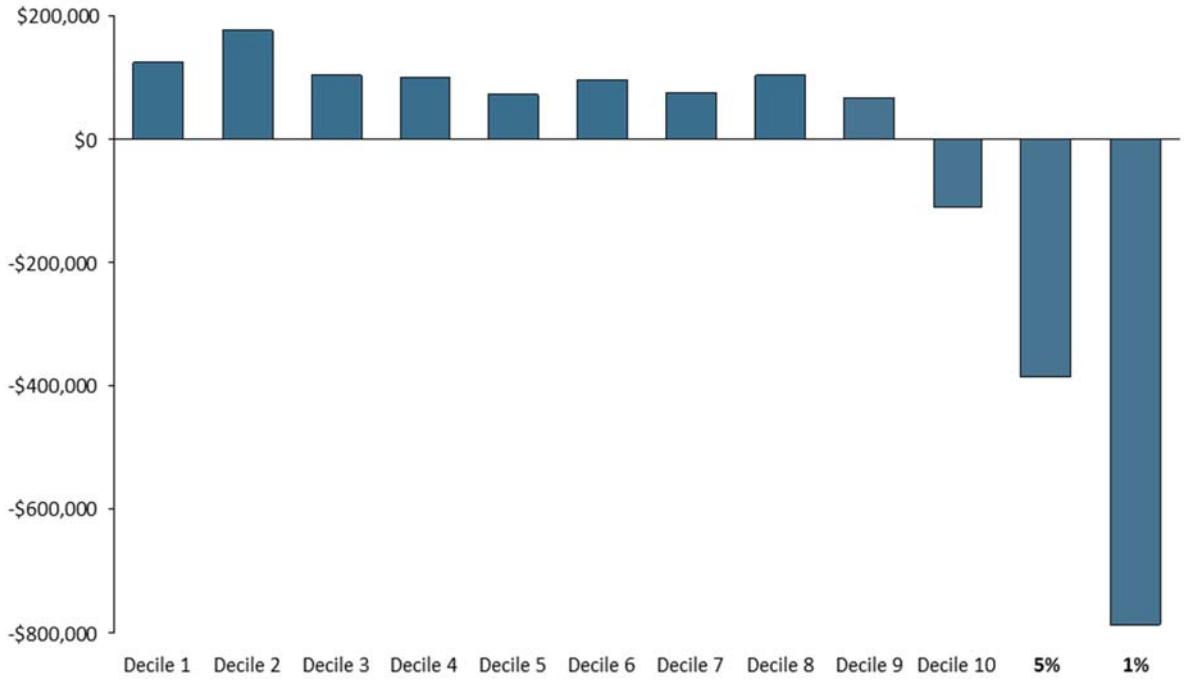
Source: ISA-Rice Warner modelling

Figure 20 – Change in life time tax concessions, single females, retiring 2055



Source: ISA-Rice Warner modelling

Figure 21 – Change in life time tax concessions, couples, retiring in 2055



Source: ISA-Rice Warner modelling

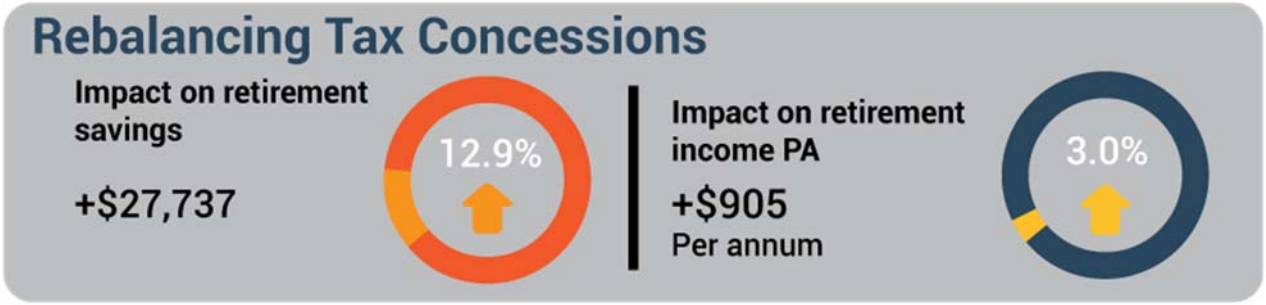
Recommendation 1: Superannuation tax concessions

ISA recommends that superannuation tax concessions be rebalanced to deliver a fair concession to low income earners, and to ensure that concessions are more efficiently directed to improving retirement income up to a comfortable level of income.

All superannuation contributions are taxed at marginal rates and will receive a 25 per cent offset on the gross contribution, which is capped at $7,500 per annum and paid to the fund. Accumulation and decumulation earnings should be taxed at 15 per cent per year, with all tax rebated for earnings below $50,000 in the retirement phase.

Example: For a taxpayer over the $80,000 threshold, their effective marginal tax rate is currently 39 per cent (37 per cent from the scales and 2 per cent medicare levy). So their employer contributions are taxed at 39 per cent whereas they were previously taxed at 15 per cent - a difference of 24 per cent. But they get a 25 per cent concession – so they are 1 per cent better off in terms of net contributions.

Figure 22 – Rebalancing Tax Concessions



Source: ISA Cameo Modelling

APPENDIX B

The ANMF's recommended strategies and policy directions for achieving savings within the health system

Attached are the ANMF's recommendations for achieving savings within the health system.

The first section, the *Economic Case for Nursing and Midwifery*, provides outlines of three examples of how significant savings can be achieved through improve utilisation of nurses and midwives and appropriate workforce reform.

The second section, *Further Recommendations*, provides a broad list of recommendations for savings within the health system, which are wider than strategies for improved utilisation of nurses and midwives.

The ANMF is very willing to provide more detailed information about the attached recommendations if required. However it should be noted, substantial detail and analysis has been provided by many health experts and health groups to the Federal Government over the last two years on these matters. It appears though, that the Government remains unwilling to recognise or act on this advice. This is with particular regard to improved utilisation of nurses and midwives and appropriate workplace reform. The Government continues to ignore advice on this matter.

ECONOMIC CASE FOR NURSING AND MIDWIFERY

Australia has a highly qualified and skilled nursing and midwifery workforce which is largely under-utilised. Nurses and midwives are denied opportunities to realise their full potential and provide maximum contribution to the health system. Opening these opportunities and undertaking appropriate workforce reform, particularly in primary care and transition care, will provide better service to more people much more cost effectively.

The following provides outlines of three simple examples of how this can be achieved.

NURSE-TO-PATIENT RATIOS/MANDATED STAFFING

A growing body of national and international research and evidence clearly demonstrates that inadequate nurse and midwife staffing leads to an increase in negative outcomes for patients, which results in increased health care costs. The implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcomes, reduce mortality and prevent readmissions thereby cutting health care costs.

> Analysis of the implementation of nurse-to-patient ratios in the US found if nurse-to-patient ratios of 1:4 were implemented nationally, 72,000 lives could potentially be saved each year. The researchers found that when nurses saved patients from pneumonia, they saved US$4,000-US$5,000 a day. When nurses prevented an adverse drug event, they saved US$1,520 a day.
>
> Research has demonstrated that the costs of additional nurse staffing is justified when the costs of adverse events are calculated. It has shown that while increasing nurse staffing by one registered nurse hour per patient day (HPPD) added US$659 to the "cost per case", each additional adverse event increased the cost per case by US$1,029 for medical patients, and US$903 for surgical patients. Costs varied according to the type of adverse event, with urinary tract infections associated with a US$1,005 increase per case, and pressure ulcers even more expensive at US$2,384 per case.[2]

NURSE/MIDWIFE-LED CLINICS

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

The following benefits have been demonstrated:

> **For patients:** patients have a shorter wait for their specialist outpatients appointments and have high levels of satisfaction with the care they receive in nurse-led clinics. This model of care can also facilitate earlier discharge of patients back to General Practice services.
>
> **For nursing staff:** Increased job satisfaction potentially resulting in increased recruitment and retention due to advanced role.
>
> **For medical staff:** Medical staff are able to concentrate on more complex patients.

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

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

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

> For example, in Europe, one randomised controlled study compared the costs of rheumatology care between a nurse-led rheumatology clinic (NLC), based on person-centred care (PCC), versus a rheumatologist-led clinic (RLC), in monitoring of patients with Chronic Inflammatory Arthritis (CIA) undergoing biological therapy.
>
> The researchers concluded that patients with CIA and low disease activity or in remission undergoing biological therapy can be monitored with a reduced resource use and at a lower annual cost by an NLC, based on PCC with no difference in clinical outcomes.
>
> The results showed the total annual rheumatology care costs including fixed monitoring, variable monitoring, rehabilitation, specialist consultations, radiography, and pharmacological therapy, generated €14107.7 per patient in the NLC compared with €16274.9 in the RCL ($p = 0.004$), giving a €2167.2 (13 %) lower annual cost for the NLC and freeing resources.

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

NURSE PRACTITIONERS

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

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

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

> For example, in some situations when a NP identifies the need for diagnostic imaging, a pathology test, or referral to an allied health professional, the provision of care is impeded and delayed as NPs are required to direct patients to an additional GP visit or spend patient-facing time undertaking administrative functions to contact GPs and request an order. If the NP can find no other alternative they may need to resort to sending the patient to the ED further contributing to overcrowding and access block.
>
> This results in:
>
> - the precipitation of an otherwise avoidable MBS consultation item;
> - delays in time to diagnosis and management which may lead to avoidable health complications for the patient;
> - an avoidable administrative burden for NPs reducing their productivity; and

- a reduction in the time available for direct patient care.

This duplication occurs while opportunities for significant cost savings go unrealised.

Take the example of an aged care NP working in metropolitan Sydney.

> The NP is employed full time Monday to Friday, with an aged care provider across 4 sites with 750 beds. The NP contributes to a specific program called RUTH (Reducing unplanned transfers to hospital).
>
> In the past 12 months, the NP has provided direct care that has prevented 55 hospital transfers. This does not include all of the situations where hospital transfer was indirectly prevented due to prophylaxis or advanced care planning, just the situations where at the point of crisis hospital transfer was called for and avoided.
>
> In order to understand the cost benefit of the NP role in hospital avoidance several calculations must be made, including the costs of ambulance transfer, ED visit, investigations, pathology tests and the cost of a hospital bed.
>
> Using conservative estimates of these costs averaged across the population of 55 aged care residents, and assuming that a transfer to hospital without admission would cost approximately $2,000 and a transfer with admission (assuming the average length of stay for this population of 11 days) would cost approximately an extra $6,000, savings can be calculated.
>
> Based on the assumption that half the residents prevented from being transferred to hospital would have been admitted, that is 27 occasions of transfer and admission at $8,000, the cost savings equate to $216,000. Assuming the remaining 28 occasions of transfer required non-admitted care in ED at $2,000 per occasion, the cost savings equate to $56,000 leading to a total of $272,000 in savings.
>
> The NP's wage is approximately $110,000 per annum with an additional earnings of $30,000 in the same 12 month period from billable items under Medicare. Using these gross calculations the net savings equate $132,000.

These are the savings created by one NP related to the 55 residents discussed. This does not take account of all the other activities performed by this NP in the normal course of her work.[3]

These snapshots provide simple examples of the potential savings and efficiencies for the health system that could be gained through better use of nurses and midwives. There are many more such examples; ANMF can provide details on request.

[3] *Detailed analysis of the economic value of nurse practitioners in Australia can be found at: https://acnp.org.au/sites/default/files/docs/final_report_value_of_community_nps_1.pdf*

FURTHER RECOMMENDATIONS

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

Restore the National Health Partnerships Agreement

- Need to return to funding models that recognise growth and use incentives to encourage efficiency.

Increase access to primary care and prevention

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

Protect the universality of Medicare

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

Cut pharmaceutical prices

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

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

- Remove the public subsidy of PHI. This could be done gradually –
    - a 10% reduction in the rebate would return significant savings to the Government even accounting for potential increase in activity to be accommodated by public hospitals with less than a 2% reduction in private health insurance coverage.[4]
    - Ancillary rebates could be cut, starting with removal of rebates for luxury items (e.g. gym memberships, running shoes and relaxation CDs) and treatments for which there is no sound evidence base.
    - Alternatively, reduce the other subsidy to the private sector: Medicare items for procedures, diagnostic imaging and pathology, which largely go to private hospitals.

[4] Cheng, T.C. 2014, Does Reducing Rebates for PHI Generate Cost Savings?, Melbourne Institute Policy Brief No. 3/13, Online: http://www.melbourneinstitute.com/downloads/policy_briefs_series/pb2013n03.pdf

Improve workforce utilisation

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

Investigate alternative revenue sources

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

APPENDIX C

Further details on the selected earnings and employment data on nurses, midwives and carers

Attached is additional information prepared by the ANMF on the employment of nurses, midwives and assistants in nursing/care workers giving regard to the hours of work and the sectors in which this work is performed. This information supplements the material previously provided to the Senate Economics Committee.

OVERVIEW OF THE EMPLOYMENT OF NURSES, MIDWIVES AND THE ASSISTANT WORKFORCE

Nurses and Midwives

The *Nursing and Midwifery Workforce Data 2014*[5] published by the Australian Institute of Health and Welfare (AIHW) provides comprehensive registration and workforce data for nurses and midwives.

The information below provides a snapshot of key workforce and employment characteristics based on 2014 data:

- Nationally, there were 352,838 nurses, (registered nurses, midwives and enrolled nurses), licensed
- Of these, 293,678 (83.2%) were registered nurses and midwives and 59,160 (16.8%) were enrolled nurses
- 91.7% of all registered nurses and midwives were in the workforce (323,711) with 300,979 employed in nursing or midwifery
- Overall, 33,114 nurses were authorised as midwives. Of these, 3,204 were registered midwives only, that is not also registered nurses
- Approximately 62% of employed nurses and midwives work in public and private acute hospitals; 11.9% in residential health care facilities; 6.8% in community health care services; 5.4% in private practice including general practice and the rest in other nursing services including government departments, schools, private industry, defence, correctional services and schools and universities
- Average hours worked by nurses and midwives: 33.3 hours per week; enrolled nurses:32 hours per week
- Almost half (48%) of employed nurses and midwives work part time
- 52.2% of the nursing workforce is aged 45 years and over with 25% aged 55 years and over

Assistants in Nursing/Personal Care workforce data in Residential Aged Care facilities

The only reliable data collection for this classification of employee is the *2012 National Aged Care Workforce Census and Survey Report*[6] undertaken by the National Institute of Labour Studies, (NILS), Flinders University and commissioned by the Commonwealth Department of Health.

- Nationally, there were 100,312 AINs/PCAs employed in residential aged care in 2012 comprising 68.2% of the direct care workforce in this sector
- 64,669 on a full time equivalent basis
- 73.6% are employed part time; 6.9% full time and 19.5% casual
- Over half (56.4%) of AINs/PCAs work from 16 to 34 hours per week; one third (32.1%) work between 35-40 hours per week;
- About two thirds have a Certificate lll in Aged Care
- Median age is 47

[5] Australian Institute of Health and Welfare, 2015, Nursing and midwifery workforce data 2014, Available online at: http://www.aihw.gov.au/workforce/nursing-and-midwifery/additional/

[6] National Institute of Labour Studies (NILS), Flinders University, 2012, *National Aged Care Workforce Census and Survey Report,* Available online at: https://www.dss.gov.au/sites/default/files/documents/11_2014/rdp004-nacwcas-report.pdf