Queensland Nurses & Midwives' Union

Submission to

Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2022-23

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Independent Hospital Pricing Authority (IHPA) for the opportunity to comment on the *Consultation paper on the Pricing Framework for Australian Public Hospital Services 2022-23* (the consultation paper).

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) and students who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 66,000 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 and midwives in Queensland are members of the QNMU. As the Queensland state branch of the Australian Nursing and Midwifery Federation, the QNMU is the peak professional body for nurses and midwives in Queensland.

The QNMU notes that we have provided two submissions to IHPA this year for the *Development of the admitted care classifications* and the *Draft Australian National Subacute and Non-Acute Patient (AN-SNAP) Classification Version 5.0 (the draft AN-SNAP V5).*

The QNMU's submission responds to the questions from the consultation paper.

What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short-term activity and potential pricing impacts of COVID-19 on NEP22?

Given there is no precedent for using a previous years cost and activity data due to a pandemic, the QNMU believes this is a sensible approach. As IHPA has noted, COVID-19 may have significant longer-term implications so perhaps a review undertaken in the following years will provide a clearer picture of whether this was an adequate approach.

The QNMU also takes the opportunity to note that in the consultation paper are 'The pricing guidelines' which include the 'system design guidelines.' These guidelines include public-private neutrality. We again advocate for nurse-to-patient ratios in public and private hospitals. Recent research into the effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay in Queensland showed that the costs avoided due to fewer readmissions and shorter length of stay were more than twice the cost of the additional nurse staffing (McHugh et al., 2021). Minimum nurse-to-patient and midwife-to-patient ratios are an economically sound methodology which saves lives and improves patient outcomes.

Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

COVID-19 has undoubtedly impacted health systems. The business-as-usual model was no longer adequate during the pandemic and required the healthcare system to become agile and adaptable. As a result, many innovative models of care have been expanded and developed during the pandemic to meet health service demands, respond to changes in work practices and community social distancing directives. These include virtual wards, hospital in the home, telehealth and fever clinics.

The QNMU has long advocated for the expansion of nursing and midwifery-led models of care to innovate, increase access to care and lead to better health outcomes for communities. The QNMU advocates for nurse-led and midwife-led models of care be identified and investigated to ensure the national pricing model reflects nurse-led and midwifery-led models of care.

Developing plans that explore historical health events and trends as well future forecasting, will ensure the health system is efficient and that the NEP and NEC for public health services are correctly determined. While some may see the COVID-19 pandemic as once in a century event, the reality is, the near future will see other pandemics. Learning what the impact of COVID-19 had on activity and cost data will be useful in developing plans for future pandemics and other health-effecting, emergent events.

Do you support the proposal to establish standard development cycles for all classification systems?

The QNMU supports standard development cycles for all classification systems.

Is there a preferred timeframe for the length of the development cycle, noting the admitted acute care classifications have a three-year development cycle?

We are satisfied with the 3-year development cycle for current classifications. However, we suggest new classifications that are introduced should have an initial shorter review period. This is to ensure the classes and subclasses are appropriate and the capturing of quantitative activity data is correct. Shortening the initial development cycle to 2 years or 1 year allows stakeholders the opportunity to address concerns or issues earlier than the 3 years. After the initial review, the standard development cycle could resume at every 3 years.

Do you have any feedback on what measures should be standard as part of the review and development of an updated version of an established classification?

As in previous submissions to IHPA, the QNMU continues to advocate for midwifery-led and nurse-led models of care and the important role they play in current clinical practice. Examples of nurse-led models of care include emergency department triage and preadmission clinics prior to surgery, diabetes education, stomal therapy and general walk-in clinics (Fedele, 2020).

Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?

As discussed in our submission to IHPA on the draft AN-SNAP V5 earlier this year, we reiterate the need to include a new subclass for custodial patients in each of the care types. Capturing this collection of data will then provide a clear picture of those who are being admitted for subacute and acute care from prisons. We ask that this be considered as part of pricing admitted subacute and non-acute services for NEP22.

How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?

While we understand the disruption that COVID-19 has caused, non-admitted care costing should be recommenced at the earliest convenience.

Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?

The QNMU submits that pricing for admitted and community mental health care be responsive and inclusive of innovative models of care. An example is the *Mental health co-responders' project* in Queensland which sees an experienced mental health nurse working

alongside either Queensland Police officers or Queensland Ambulance paramedics. When police or paramedics respond to police call-outs or ambulance call outs where mental health might be a factor, these nurses are able to provide immediate assessment and advice. This may prevent some hospitalisations as nurses are able to provide care in the call-out location. Given this is a recently introduced model of care, we ask this model of care be included in the classification system for mental health services.

The QNMU also takes the opportunity to address *5.7 Teaching and training* (page 17) in the consultation paper and ask that nursing and midwifery research be included in teaching and training activities.

What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?

The QNMU supports IHPA's proposal to consider an adjustment for patient transport in rural areas. For most rural and remote communities, equitable access to health care is restricted by the need to travel great distances to access care, difficulty accessing specialist and general practice (GP) services, limited access to transport and high cost of travel and accommodation (AIHW, 2019).

Whilst the existing national pricing model includes patient residential and treatment remoteness adjustments, the current scheme fails to address the broad ranging geographical barriers to accessing health care.

The QNMU considers the following should be captured by the existing adjustments:

- The cost of support for escorts to accompany patients from their rural and remote homes to specialist care;
- The disadvantages faced by patients who travel independently;
- Better use and investment into telehealth services to reduce unnecessary travel to hospital and health services;
- Onerous amount of time required to arrange and coordinate travel:
- Personal safety concerns when using public transport (Kelly et al., 2014);
- Cost of travel;
- Cultural and linguistic barriers to arranging and coordinating travel (Kelly et al., 2014);

Aboriginal and Torres Strait Islander peoples face a range of social determinants of health that impact access to care. Research indicates that unemployment and poverty inhibit Aboriginal and Torres Strait Islander people's ability to afford transport and associated services. The lack of access to culturally appropriate services within communities also hinders communication and coordination of transport services (AIHW, 2013). The QNMU considers that future adjustments must consider the impact that cultural and social determinants of health have on the physical accessibility of care.

The QNMU notes that adjustments to the current scheme should provide sufficient incentives for nurses and midwives to re-locate to rural and remote areas. In a survey conducted by the QNMU in 2020 of our rural and remote members, reported that a lack of access to safe and affordable transport and accommodation were key barriers to re-location (QNMU, 2020).

What factors should IHPA consider in reviewing the Specified Intensive Care Unit eligibility criteria and adjustment?

The QNMU provides no further comment.

What factors should IHPA consider in reviewing the Indigenous adjustment?

One of the primary reasons for including an Indigenous adjustment in activity-based funding (ABF) is to ensure that hospitals are provided with sufficient funding to ensure that funding is directly related to the cost of care. The QNMU considers that appropriate weighting of activities is required to incentivize equitable delivery of care.

The QNMU suggests the following be included in reviewing the Indigenous adjustment:

- Affordability of accommodation in rural and remote areas for health practitioners;
- Longer consultation times to enable opportunistic care to patients and their families;
- Costs associated with relocating patients and their families in order to access care;
- Improving the identification of Aboriginal and Torres Strait Islander people according to national best-practice guidelines;

Whilst the QNMU acknowledges that IHPA preferences the ABF model, the QNMU strongly advocates for an outcomes-based funding model that focuses on improving patient health outcomes. In our view, ABF is inadequate to provide the required care for Aboriginal and Torres Strait Islander peoples. We urge IHPA to review the benefits of a value-based funding strategy to provide a patient-centric way to manage and fund health systems.

What evidence is there to support increased costs for genetic services or socioeconomic status?

Whilst the QNMU makes no comment about support for genetic services or socioeconomic status, we raise the need for increased costs for social determinants of health. We emphasise the significance of addressing social determinants of health in order to achieve equitable and stronger health outcomes for communities, groups or individuals.

What evidence can be provided to support any additional adjustments that IHPA should consider for NEP22?

The COVID-19 pandemic has caused a shift in the modality of service delivery. As such, we support the use of technology enhanced care, such as telehealth to improve provisions of

health services, particularly in rural and remote locations (Monaghesh et al, 2020). We encourage IHPA to consider adjustments for telehealth and technologies. Whilst telehealth does not replace the importance of human connectedness or the need for appropriate face-to-face appointments and clinical examinations, the value of telehealth in the right context is considerable.

Are there other clinical areas where introducing price harmonisation should be considered?

The QNMU believes that the objective for price harmonisation should be to facilitate best practice and enable nurses and midwives to provide adequate health care services. We encourage IHPA to base price harmonisation on the principles of value-based healthcare. The QNMU has long advocated for a value-based model as it places the focus on patients and patient outcomes (Porter, 2010). We consider that value in health care is the measured improvement in a person's health outcomes for the cost of achieving that improvement (Teisberg et al., 2020). As such, we consider that financial incentives should drive outcomes-based and person-centred care. We also consider that price harmonisation should aim to provide a standardised quality of care to create a more equitable health system for all.

What factors should IHPA consider in investigating whether methodology changes are required for funding unqualified newborns?

The QNMU continues to advocate for bundled pricing for maternity care. One major concern we believe is that funding models do not currently recognise a newborn as a separate entity unless the newborn is considered 'qualified'. Newborn babies who remain with their mother post birth are not counted as an additional patient, despite requiring care from midwives and other considerable hospital resources. The current system does not account for the considerable workload burden and level of care required to support mothers and babies.

The 'qualified baby' is defined under *Health Insurance Act 1973* regulations as a funded patient where:

- They occupy a bed of an accredited neonatal intensive care facility;
- They are a second or subsequent child of the same mother; or
- They are admitted without their mother.

Qualified babies can receive neonatal care where newborns are suffering from an illness or disability and could involve monitoring, oxygen therapy, administration of IV drugs or postsurgical care. Babies requiring care such as phototherapy, drug administration and monitoring on the postnatal ward creates additional work for the midwifery staff, for which health services are not funded.

The QNMU considers the need for a review of funding models to provide care to newborns. Funding for inpatient postnatal care must include a separate allocation of the newborn.

Alternatively, funding for the mothers should be increased to account for the increased workload generated by the care of mother and baby.

Currently, most hospital staffing models are based on the number of inpatient mothers, where only the mother's care is funded. This funding model is reductive and can lead to unsafe staffing practices. Bundled pricing for maternity services could be used to provide an incentive for hospitals to practice evidence-based care and improve the safety and quality of care delivered to mothers and babies. The increased acuity of mother's results in increased demand on care requirements for unqualified babies.

The QNMU recommends that IHPA align bundled pricing with evidence-based models of care to reinforce the implementation of best practice in public health services. We believe that midwifery models of care could be well supported by the introduction of bundled payments. The QNMU also recommends funding for midwifery-led models of care in rural and remote locations. We believe that funding models should work to reduce health inequities faced by vulnerable populations and rural or remote communities.

Are there any objections to IHPA phasing out the private patient correction factor for NEP22?

Our submissions to IHPA in previous years, have stated that we have not had an opinion either way on phasing out the private patient correction factor. Given it has already been removed in the Northern Territory we therefore now support that the private patient correction factor be phased out elsewhere in Australia.

What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?

The QNMU suggests there may be a negative impact of transition block funded standalone hospitals that provide specialist mental health services to ABF, given they are already under-resourced. We believe that outcomes-based funding could be applied in this instance where funding models are patient-centred and incentivise for quality and best-practice outcomes.

What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

As previously mentioned, the QNMU seeks greater funding recognition for innovative nurse and midwifery-led models of care, particularly models that enable nurses and midwives to work to their full scope of practice. As such, we suggest the IHPA consider the following models.

Nurse Navigator

A Nurse Navigator is an RN who provides a service for patients who have complex health conditions and require a high degree of comprehensive, clinical care. They have a critical role to play in coordinating health care particularly in regional Australia. Nurse Navigators support and work across system boundaries and in close partnership with multiple health specialists and health service stakeholders to ensure patients receive the appropriate and timely care needed.

During the pandemic, nurse navigators have responded with innovative solutions to health care concerns. Key examples of nurse navigator's flexibility are demonstrated by the development of virtual models of care in the community, enhancing Hospital in the Home (HITH) and Hospital in the Nursing Home (HINH) models. These models were highly successful in keeping vulnerable populations outside of the acute hospital system during this crucial time. The advancement of such models will greatly support the necessary shift to a better integrated and high value health system.

Nurse Practitioner

The NP is an experienced Registered Nurse educated to Masters Level and competent to function autonomously and collaboratively in an expanded clinical position. NPs have their own distinct role and scope of practice. In our view, NP- led models of care will work to reduce the burden on hospital services and improve the delivery and efficiency of care across services. The role of NPs should be further explored when considering innovative funding models.

Midwifery

The QNMU strongly recommends funding recognition for midwifery-led models of care and there is a growing body of research to support this. For instance, a recent study conducted by Callander et al (2020) examined the cost-utility of a publicly funded Midwifery Group Practice model of care compared with other models of care. It was found that the cost of midwifery led care was 22% less than other models with no significant differences in Quality Adjusted Life Years (QALYs) (Callander et al., 2021).

The QNMU also asks IHPA to consider funding for midwifery in rural and remote hospitals. These models are evidence-based and focus on woman-centred care being delivered by a primary midwife starting from early stages of pregnancy, through to six weeks post birth. There are several benefits to midwifery-led continuity of care for women including a significant reduction in interventions such as epidurals, episiotomies and instrumental births as well as a reduced likelihood of preterm birth or losing their baby before 24 weeks gestation (Sandall et al., 2013).

Aged Care

The QNMU considers the *Royal Commission into Aged Care Quality and Safety* recommendations to be integral to informing funding approaches to aged care and increasing better interfaces between health care systems. The QNMU welcomes *Recommendation 115* of the Royal Commission report to expand IHPA's scope by renaming the authority to the Independent Hospital and Aged Care Pricing Authority (IHACPA). We again encourage an outcome driven pricing model that focuses on high quality and person-centered care. We note that the IHACPA should take into account the pay required to attract a sufficiently staffed and skilled workforce with the capacity to deliver high quality care.

We also consider the need for palliative care to be a key funding focus.

What innovative models of care or services are states and territories intending to trial for NEP22?

The QNMU acknowledges the work of the Institute of Urban Indigenous Health (IUIH) in developing a model of care based on best practice from Aboriginal/Torres Strait Islander and mainstream service providers. The model of care provides customised, system-based, urban Aboriginal and Torres Strait Islander Community Controlled designed and led approach to the delivery of accessible, efficient, effective and primary health care (IUIH,2019). The QNMU suggests that IHPA further investigate adapting the IUIH model of care to the NEP22 context.

What should IHPA consider when developing evaluation measures for evaluating safety and quality reforms?

The QNMU suggests the experience of the Queensland Geriatric Emergency Department Intervention (GEDI) as a case study for developing and evaluating safety and quality reforms. The GEDI service may absorb, replace or collaborate with a range of services to provide support for frail older people in the emergency department (ED). The model operates to bridge the gap between aged care and acute care through the integration of health service delivery (Queensland Government, 2020).

What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?

Models of care

The QNMU suggests funding adjustments for avoidable hospital readmissions should be evidence-based, timely and cost-effective. As mentioned in previous submissions, we strongly recommend greater funding recognition for nursing and midwifery led models of care as a key strategy to reduce avoidable and preventable hospitalisations.

Data collection

The QNMU also suggests the inclusion of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience measures (PREMS) in funding approaches to reduce avoidable and preventable hospitalisations (ACSQHC, 2016). Expanding the collection of data is a key objective in reducing avoidable and preventable hospitalisations. The tracking of health outcomes including avoidable hospital readmissions and the costs involved is fundamental in value-based healthcare delivery (World Economic Forum & Boston Consulting Group, 2017).

Hospital in the home

Hospital in the home (HITH) is a service that has been adopted in QLD to support patients, particularly in residential aged care facilities (HINH), to avoid unnecessary hospital admission or re-admission. The role of nurses is critical in coordinating care across acute and non-cute settings and providing communication between patients, families, aged care residential facilities and primary health services. The model has successfully been expanded and adapted to reduce hospital admissions during the COVID-19 pandemic as well as to minimise the risk of COVID-19 exposure to staff and patients. The QNMU recommends that IHPA explore the uses of HITH to improve care at home and as a useful strategy to avoid hospital admissions.

What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?

The QNMU's long held position is that an incentive approach rather than a punitive approach is best when assessing different pricing and funding approaches for reducing avoidable and preventable hospitalisations. We believe caution must be practiced to ensure a workplace culture of openness and fairness rather than one of blame. Further, a reduction of funding, or financial disincentives will potentially have a negative impact on hospital care as facilities try to handle reduced budgets.

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