Queensland Nurses & Midwives' Union

Submission to

Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2023-24

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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 2023-24* (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 65,000 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's submission responds to the questions from the consultation paper.

Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

What became clear with the outbreak of COVID-19 was that the previous years of leaning the Australian health care system by removing 'waste' and 'excess' from the health care system, had effectively removed any extra system capacities that supported resilience in responding to the pandemic (Clay-Williams, Rapport & Braithwaite, 2020). We suggest that as part of assessing the impact of COVID-19 on the 2020-21 data, that the national efficient price (NEP) 23 factor the cost of planning and preparing for future pandemics with the aim of ensuring a more resilient health care system.

The direct impact of COVID-19 on hospitals has been unprecedented with not only the number of COVID-19 positive patients being admitted to hospitals, but hospitals having to provide screening and testing for COVID-19, personal protective equipment (PPE), patient isolation facilities, greater capacity in intensive care units and reductions in ward capacity. While cost data analysis has shown hospital expenditure throughout the pandemic has remained stable there has been a reduction in activity and an increase in supply expenses and consumables such as PPE. As IHPA has noted in the consultation paper, the longer-term impacts of those who have a post-COVID condition, and those who have had to defer or cancel care, treatments and surgeries during the pandemic will impact activity and cost in Australian public hospitals. We are therefore supportive for IHPA to develop a plan for assessing COVID-19 impacts on the 2020-21 data and the implications of the development of the NEP 23.

The QNMU believes that the outbreak of COVID-19 has prompted a welcomed review of the broader health care system. How health care is accessed, the health care workforce and the roles each health practitioner plays have been brought to the forefront, showing that the health care system must not only meet the needs of patients but be responsive and sustainable and support health care workers to perform their roles. To that end, we therefore take the opportunity to advocate for the reestablishment of Health Workforce Australia (HWA) which was abolished in 2014. HWA was an initiative of the Council of Australian Governments and was established to address the challenges of providing a skilled, flexible and innovative health workforce. If a body like the HWA was re-established IHPA could work with them in collecting and using data on critical priorities in the planning, training and reform of Australia's health workforce not only for assessing the impact of COVID-19 but on the future development of NEPs.

Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?

The outbreak of COVID-19 placed a massive burden on the health care system and health care workforce. The pandemic exposed the gaps and strains on the system from the initial lack of a surge workforce, to supply chains and shortages of equipment. The health care system had no in-built 'slack' to buffer the impact of COVID-19 on the health care sector and had to meet

the emerging pandemic from a standing start. The QNMU therefore strongly asserts that with any pursuit in efficiencies or streamlining in our public health system there must be built in, sufficient excess capacity to cope with any surges in demand and crises. This then will help hospitals to have the capacity to not only treat acute episodes of care but all care. Efficiency is misnamed if it impedes the capacity and capability of the health system to meet a crisis.

The QNMU also asks that IHPA consider programs that incentivise non-admitted care focusing on prevention, health and wellbeing. This aligns with Queensland Health's report *Unleashing the potential* (the report) (Queensland Health, 2020), where a Reform Planning Group was established to investigate how to harness opportunities that arose from dealing with the pandemic and how health care was delivered during this time. One of the recommendations from the report is to make prevention and public health a system priority which we believe would have a flow on effect on potentially reducing the number of patients who would need to access admitted acute services.

As the QNMU has stated in previous years in our submissions to IHPA on the pricing framework for Australian public hospital services, we continue to advocate for nurse-to-patient and midwife-to-patient ratios in public and private hospitals. Recent research undertaken to assess the effects of implemented minimum nurse-to-patient ratios in Queensland, found that minimum nurse-to-patient ratio policies are a feasible approach to improve nurse staffing and patient outcomes with good return on investment (McHugh et al, 2021). With health spending on hospitals accounting for 36% of total health spending in 2000-01 and increasing to 40% of total health spending in 2017-18, (Australian Institute of Health and Welfare, 2020a) the QNMU believes innovative models of care and alternatives to service delivery that are provided by nurses and midwives are necessary for the sustainability of Australia's public hospital services.

Do you support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

The QNMU supports IHPA's approach in refocusing resources to ICD-11 readiness. In our view one of the key readiness projects must be emergency care. Patient demand for health care services has been brought to light by the COVID-19 pandemic, and yet emergency departments (EDs) and hospitals were already experiencing increased demand even before the virus hit Australia. The reasons are many as to why EDs are overcrowded but include:

- the capacity of a hospital's inpatient services cannot meet demand;
- patients in hospital beds waiting on the National Disability Insurance Scheme (NDIS) services or aged care facilities to receive discharged patients;
- lack of alternative community-based health services for people to access so they present to emergency departments;

- supply of workforce, short term and long term;
- an ageing population experiencing more complex health care needs;
- demand for services has outpaced population growth. In 2019/20, there were more than 1.6 million presentations to public hospital emergency departments in Queensland - a third arrived by ambulance (Queensland Audit Office, 2021). Across Australia, people presenting at public emergency departments increased by 3.2% on average each year from 2016-2017 (Australian Institute of Health and Welfare, 2019).

The position of the QNMU is that the disruption caused by the pandemic provides an opportunity to reset the health care system. In response to the pandemic, new processes were introduced that increased the capacity of EDs such as streamlined pathways for common ED presentations, COVID-19 fever clinics and the implementation of new or expanded community-based and telehealth ED-substitution programs (Queensland Health, 2021). We suggest there is a readiness for change in practices and behaviours and gains in progressing system reforms (Queensland Health, 2020).

The QNMU also takes the opportunity to suggest that as part of the readiness project in preparing for ICD-11 is a review into the impact COVID-19 had on health care systems. The business-as-usual health care model came under strain during the pandemic forcing the health care 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, fever clinics and dedicated post-acute and long COVID clinics.

The QNMU also advocates for the expansion of nursing and midwifery-led models of care to innovate, increase access to care which leads to better health outcomes for communities and should be identified and investigated to ensure the national pricing model reflects nurse-led and midwifery-led models of care.

Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

As discussed in our submission to IHPA last year on the draft AN-SNAP V5, the QNMU continues to advocate for the inclusion of a new subclass for custodial patients in each of the care types. Capturing this data will provide a clear picture of those who are being admitted for subacute and acute care from prisons.

Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

The QNMU has long supported mental health care delivered in the community thereby shifting the burden from hospitals. With statistics showing that people seeking mental health-

related services in EDs being 3.8% of all presentations in EDS in 2019-2020 which was slightly higher than the previous year where there 3.6% presentations, there is a need to shift care to the community not only now but to ensure sustainability of health care system into the future (Australian Institute of Health and Welfare, 2022). We ask IHPA to consider the different types of community mental health care for NEP23 that includes not only medical models but other health practitioners including nurse-led models of care.

There are already successful models of care being delivered that are non-hospital services such as the mental health co-responder program. This sees police officers and mental health nurses determine if a person in crisis can be treated in their home rather than taking them to hospital.

Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

To achieve a financially sustainable health care system with a consistently high quality of care, the QNMU suggests IHPA consider:

- Investigating the viability of establishing an innovation fund which could be used to trial and evaluate new models of funding which would complement the current Activity Based Funding (ABF) model in order to:
    - address demand;
    - improve performance, capacity and innovation;
    - support integrated care that coordinates and fosters connectivity between health care providers in primary care, community services and hospitals; and
    - provide greater access to health resources and better weighted funding models to First Nations people and other disadvantaged groups to improve nonmedical and medical conditions which influence health outcomes (The QNMU discusses a current system of care model utilised by the Institute for Urban Indigenous Health (IUIH) in this submission).

Some of the models of funding that the QNMU is strongly supportive of are funding models that support value-based care including:

- Providers being paid for services if they achieve specific pre-defined outcomes. i.e.
    - Outcomes based funding where some or all the contractual payments is conditional on specific outcomes being achieved.
    - Performance incentive funding where providers are awarded incentive or bonus payments for achieving certain outcomes
    - Social investment bonds where a financial instrument that can be backed by either private or government funding, or both (PricewaterhouseCoopers, 2018).
- Bundled payments for a ‘bundle of activity’ or an end-to-end episode of care.

- Alliance contracting which is a group of health care providers entering into an agreement to deliver health care services under pre-agreed terms (Queensland Nurses and Midwives' Union, 2021).

The QNMU also continues to advocate for bundled pricing of maternity care. IHPA states in the consultation paper that unqualified newborns are not currently accounted for in the national pricing model and that previous stakeholder feedback has sought IHPA to consider their inclusion. The QNMU is one of these stakeholders. We strongly support the inclusion of newborn babies in the national pricing model and have been running a campaign for "Count the babies" advocating for safe workloads in midwifery, with a focus on counting babies in workloads in postnatal inpatient units (Queensland Nurses and Midwives' Union, 2022).

Newborn babies who remain with their mother post-birth should be counted as an additional patient, as excluding them is to ignore the care they receive. Infants may require neonatal care that is outside of an intensive care unit where they may be suffering from an illness or disability and may need monitoring, oxygen therapy, administration of intravenous (IV) drugs, post-surgical care, phototherapy and drug administration, which is additional work for the midwifery staff, for which health services are not funded. The QNMU therefore, continues to advocate for the inclusion of a newborn as a separate entity with funding for inpatient postnatal care as 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. Patient safety must be the cornerstone of health system and payment models should be a driver in this regard. Not including most newborns in the funding model does little to promote this fundamental system characteristic.

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 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.

What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

We suggest that end-of-life care for those who die from COVID-19 be considered as a cost input pressure that may impact on the national pricing model and be considered in the development of the NEP23.

Which initiatives to refine the national pricing model should IHPA prioritise?

In the consultation paper, IHPA highlights that in 2021 they intended to investigate several areas when looking at adjustment to the NEP, which the QNMU is supportive of. We draw particular attention to the consideration for a new adjustment for socioeconomic status. Non-medical factors such as employment and occupation, income, education, housing, social support, and gender are linked to a lack of opportunity and resources to protect, improve, and maintain health (Centers for Disease Control and Prevention, 2022). To align with value-centred care and to make an impact on improving health equity, the QNMU believes it is necessary to record and analyse social determinants of health data to better understand and address the underlying cause of poor health and potential drivers of improving health.

Another initiative is nurse-led and midwife-led models of care in the national pricing model. We strongly assert that expanding nurse and midwife-led services has the potential to create a more accessible, productive, and safe health care system. One model is the Nurse Navigator who are RNs involved in clinical integration, coordination of patient care and providing education and points-of-contact for health practitioners. Research demonstrates that nurse navigation models reduce costs and length of stay in hospital (Hannan-Jones, Young, Mitchell & Mutch, 2019). One example is the Nurse Navigator Service in the Torres and Cape Hospital Service (TCHHS) in Queensland which has made a positive impact, showing a 61% decrease in visits to ED, a 77% decrease in unplanned re-admissions to ED, a 58% decrease in hospital bed days per month and a 61% decrease in total hospital bed days. In two months alone in 2018, $86,000 was saved in patients' travel costs. (Queensland Government, 2019a).

Nurse Practitioners (NPs) are another advanced practice role successfully working in Queensland. They are experienced RNs educated to master's level and competent to function autonomously and collaboratively in an expanded clinical position. KPMG (2018) for the Department of Health, identified that NP models deliver a positive return on investment particularly in aged care where NP models can help reduce avoidable ED visits and hospitalisations.

A further innovation are midwife-led models of care which is provided by a single midwife or small group of midwives through pregnancy, birth and the early parenting period. These models of care have been shown to reduce medical interventions for women and reduce the rates of preterm babies when compared with standard care (University of Technology Sydney, 2020).

What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?

The QNMU supports additional data sources and the expanding of collection of data to support the refinement of the national pricing model but have no additional data sources to recommend at present.

What cost pressures for regional or remote hospitals should be considered in the development of NEC23?

Cost pressures experienced by regional or remote hospitals include:

- Workforce salaries are high due to:
    - Staff entitlements for remoteness and recruitment;
    - Relocation fees;
    - Agency fees
    - Accommodation for the workforce which may be subsidised or provided (Gorham, et al., 2019).
- Potentially preventable hospitalisations where hospitalisation could have potentially been prevented through the provision of appropriate primary and preventative care that may not be available in regional and remote areas (Australian Institute of Health and Welfare, 2020b).
- Higher incidence of chronic health conditions for those living outside of major cities (Australian Institute of Health and Welfare, 2020b).
- Transport costs to have medical supplies, consumables and food transported from metropolitan areas.

As stated in previous years in our submissions to IHPA, the QNMU continues to support 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).

What specific areas of the Local Hospital Networks and Public Hospital Establishments National Minimum Data Set would you recommend IHPA focus on when developing its independent quality assurance process?

The QNMU supports timely, consistent and transparent reporting including how government subsidies are spent.

What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

The QNMU suggests consideration be given as to the location of standalone hospitals providing specialist mental health services when transitioning to ABF. The Modified Monash Model (MMM) could be one tool used to determine the remoteness and population size of the location of the hospital ensuring mental health services are not removed or relocated when there are no other mental health services available in that location. Those who need to access mental health services must not be disadvantaged due to where they live. Consideration must be given as to the mental health services provided in communities so that care is not rationed due to lack of mental health services.

With IHPA highlighting the in-reach models of care that have been established in some regional hospitals in the consultation paper, it shows the complexity and variability of mental health services and the needs of patients. We concur with IHPA that mental health services provided 'in place' alleviates pressure on metropolitan hospitals and health services.

How is virtual care delivery captured in information systems and data collections?

The QNMU supports data collection of all virtual care delivery including one-to-one health care, group sessions, multiple health care providers and multi-disciplinary telehealth consultations.

IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?

The QNMU is supportive of IHPA investigating further models of care and services related to virtual care. Virtual care is another way of delivering health care services and while its use may have been expediated in response to the pandemic, it would be a mistake to revert to pre-pandemic health delivery models, given the uptake and success of virtual models. We suggest these models for further investigation:

- *Virtual diabetes clinics* are Nurse Practitioner-led virtual care that provides another tool or option for diabetes care and uses technology and devices to record and monitor patient conditions. It is safe, time efficient and cost efficient for patients as they no longer need to travel for appointments.
- *Virtual outpatient integration for chronic disease* (VOICeD) model of care is being trialled in Queensland, where a person with chronic disease can see multiple health care practitioners at one appointment, via telehealth. The model is anticipated to be adaptable for specialist health practitioners, nurses or allied health-led care (Queensland Government, 2022).

- *Hospital in the home* (HITH) is a hospital avoidance strategy implemented to treat and monitor patients in the home with services offered by nurses and other health practitioners.
- *13Health* or telephone triage is a telehealth service where nurses can assess symptoms and provide health advice to those seeking health information using a range of protocols to guide the triaging process (Queensland Government, 2019b).
- *Mental health co-responder program* where those in mental health crises are assessed at home by a mental health nurse with a police officer rather than taking them to hospital (previously discussed in this submission
- *Walk-in centres*, as seen in the Australian Capital Territory (ACT) are a network of nurse-led clinics where Nurse Practitioners or advanced practice nurses provide free health care advice and treatment for non-life-threatening injuries or illnesses thereby taking the pressure off emergency departments.
- *Midwifery community access program* at the Townsville HHS. This midwife-led model of care program is about ensuring pregnant women in the community get antenatal care early and regularly, rather than just when they give birth. It aims to reduce discharge against medical advice, failure to attend antenatal appointments and reduce high levels of smoking during pregnancy, and consequently improve health care outcomes for Aboriginal and Torres Strait Islander women and their families. This program provides culturally safe care and increases access for First Nations women to a Clinical Midwife Consultant (Queensland Nurses and Midwives' Union, 2020).

What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?

The development and use of innovative models of care and services related to virtual care have undoubtedly been successful during the pandemic. A study by Flinders University (Gray, Partington & Karnon, 2021) during the first wave of COVID-19 in Australia found that of patients who experienced a health issue for which they would normally present to an ED, 35% contacted another health care provider, and either had face-to-face or telehealth appointments and 40% of this cohort was able to avoid presenting to an ED, thereby taking this patient workload off EDs. Other virtual care models included COVID-19 virtual wards which provided monitoring and support services for the length of time patients were required to isolate, with a patient pathway to receive further care if their condition deteriorated as well as virtual EDs (Queensland Government, 2020). We view the success of virtual care as being attributed to patient and health practitioners' willingness to use this model and government investment which enabled greater access to care.

While these models of care have been in response to the pandemic, we believe that part of their successful use and uptake has been because they have addressed gaps in health care delivery. This success shows virtual care should be made a permanent part of health care

delivery. The QNMU therefore encourages IHPA to consider adjustments for virtual care. However, we cautiously acknowledge that if virtual care is the only health care option for patients, there is the possibility that patients may choose to self-manage and not seek health care. In the study by Flinders University (Gray, Partington & Karnon, 2021) it was found that 10% of their survey respondents self-managed their health condition during the pandemic, choosing not to use telehealth, thereby suggesting access issues for virtual care is an important consideration in this type of care. Whilst virtual care does not replace the importance of human connectedness or the need for appropriate face-to-face appointments and clinical examinations, the value of virtual care in the right context is considerable.

The QNMU also supports funding models and innovative models of care that target social determinants of health, particularly for high-risk populations including Aboriginal and Torres Strait Islander populations to work towards closing the health inequity gap. In our submission to IHPA last year, we highlighted 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. IUIH coordinates and integrates primary and preventative health care, the hospital system and addresses social determinants of health by supporting their clients to access other social assistance and wraparound services (Queensland Aboriginal and Islander Health Council, 2021). This model of care has achieved significant outcomes including improvements in Health Adjusted Life Expectancy (HALE) of 0.4 years and has been steadily increasing their access to health care services (Queensland Aboriginal and Islander Health Council 2021). The QNMU views IUIH's system of care as innovative and we would support IHPA in reviewing this type of model of care in future funding.

The QNMU also takes the opportunity to raise concerns around short funding cycles particularly for community-based organisations. Cutting funding short, impacts job security and causes workforce issues such as recruitment challenges for short-term positions for those who work in these organisations, as well as limiting long-term planning for services and poorer outcomes for patients or participants. We support state and federal governments reviewing current funding and contracting arrangements so that the flow-on effects of not renewing these services does not impact patients nor the greater health care system.

The QNMU also wishes to highlight the current funding restraints for nurses and midwives in their ability to work to their full scope of practice and their unequal access to the Medicare Benefits Schedule (MBS). We continue to seek:

- increasing access to the MBS, recognising nurses and midwives are equal and valued members of the health care team and to cover the delivery of all nursing and midwifery services;
- implementing the recommendations provided by the Nurse Practitioner Reference Group (NPRG) to the MBS Taskforce related to NP services. The NPRG was formed to provide recommendations to the MBS Taskforce related to NP services. The NPRG

offered 14 recommendations all of which were for funding of services that NPs already provide. The MBS Taskforce did not accept any of these recommendations and offered three alternative recommendations which showed a distinct lack of understanding of the role of NPs, were not evidence-based, and would impose additional restrictions on services provided by NPs (Chiarella & Currie, 2020);

- increasing funding to support midwifery primary health care models as most pregnant women achieve better outcomes with primary health care by a known midwife. During health crises, hospitals are known to be areas of higher clinical risk; primary health care enables safe care for a well population who have specific fears and anxieties (Bradfield, et al., 2021).

It is the QNMU's that hope once the government has removed these funding barriers for nurse-led and midwife-led models of care, that IHPA will consider these models of care in the national pricing model.

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