Queensland Nurses & Midwives' Union

Submission to

Independent Health and Aged Care Pricing Authority

Pricing Framework for Australian Public Hospital Services 2024-25

July 2023

106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

submission

Table of Contents

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Independent Health and Aged Care Pricing Authority (IHACPA) for the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25* (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 71,000 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 (ANMF), the QNMU is the peak professional body for nurses and midwives in Queensland.

Through our submissions and other initiatives, the QNMU expresses our commitment to working in partnership with Aboriginal and Torres Strait Islander peoples to achieve health equity and ensure the voices of Aboriginal and Torres Strait Islander nurses and midwives are heard. The QNMU supports the Uluru Statement from the Heart and the call for a First Nations Voice enshrined in our Constitution. The QNMU acknowledges the lands on which we work and meet always was, and always will be, Aboriginal and Torres Strait Islander land.

We commend IHACPA for investigating the current funding model in accounting for unqualified newborns. We have long campaigned for all babies to be counted in midwives' workloads. The QNMU thanks IHACPA for meeting with us and discussing the review of the pricing model for unqualified newborns and look forward to further discussions.

The QNMU's submission responds to the questions from the Consultation Paper.

Are there any significant barriers to pricing admitted subacute and non-acute care using AN SNAP Version 5.0 for NEP24?

As discussed in submissions to IHACPA in previous years, 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. We ask that this be considered as part of pricing admitted subacute and non-acute services for NEP24.

Whilst not necessarily a barrier to pricing admitted subacute and non-acute care, we take the opportunity to recognise the impact on hospitals when aged care residents require admission to hospital. These people often have higher acuity and special needs and finding appropriate accommodation for them across their length of care can be difficult. Reducing exit blocks for patients to return to their residential aged care facility and not remain in hospital for longer than is necessary, is essential.

Are there any other areas in the AECC that IHACPA should consider as part of the classification refinement work program?

The QNMU supports IHACPA's intent to review the first completed year of the more detailed data set to assess the appropriateness of pricing emergency services using the Australian Emergency Care Classification (AECC) in the future.

The QNMU submits that nursing procedural work in emergency departments (EDs) be coded in the Emergency Department Information Systems (EDIS). More detailed patient data collection that captures all patient care including the assessment, investigation, intervention and discharge performed by nurses and Nurse Practitioners should be mapped and priced accordingly.

We also suggest consideration be given to the collection of patient data of those who present to EDs due to the lack of bulk billing general practices and/or accessibility and availability issues in finding a timely General Practitioner (GP) or Nurse Practitioner appointment. We know EDs are getting busier, and this is due in part, to patients who would normally visit a general practice seeking care from EDs. In 2020-21, there were 343 presentations per 1,000 population, equivalent to over 8.8 million total presentations to public hospital EDs in Australia (Australasian College for Emergency Medicine, 2022). This ED overcrowding is unsustainable and is a serious symptom of a healthcare system under enormous strain. While we acknowledge these patients are captured in the AECC, further refinements may look to include details about the healthcare costs of these type of patients.

What clinical areas and/or structural features should IHACPA consider in the development of the EPD Short List Thirteenth Edition?

The Royal Commission into Aged Care Quality and Safety identified that data collection of hospitalisations of people living in residential aged care are important for monitoring the quality of aged care services and the health and safety of these patients. To that end, the QNMU proposes that models like the Geriatric Emergency Department Intervention (GEDI) which focusses on providing care to older people presenting to EDs, could be one clinical area that can be explored by IHACPA to identify effective and efficient emergency care.

We also suggest that IHACPA consider the multidisciplinary approach to providing care in EDs and their effectiveness in improving patient care.

Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25?

In using the health information available within jurisdictional electronic medical records (eMR), we suggest consideration be given in how to capture the activity outside of these jurisdictions as eMRs are not used in all settings.

Following three years of shadow pricing and the development of risk mitigation strategies to support the transition to ABF, are there any significant barriers to pricing community mental health care using AMHCC Version 1.0 for NEP24?

The QNMU has long supported mental health care delivered in the community thereby shifting the patient burden from hospitals as well as bringing patient care closer to home. We contend that while it's not a barrier to pricing community mental health care, pricing all community mental health care models such as medical models, nurse-led models and other health practitioner models, will increase access to community mental health 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 an experienced mental health nurse work alongside Queensland Ambulance Service (QAS) paramedics to determine if a person is experiencing a mental health crisis and can be treated in their home rather than taking them to hospital (Queensland Government, 2023a). This program, along with other multi-disciplinary programs must also be considered in pricing community mental health care.

Are there any other measures that will assist in transitioning community mental health care from block funding to ABF for NEP24?

The QNMU suggests monitoring this change in funding approach given the current block funding of community mental health services often allows for greater flexibility as to where the funds are allocated and can be cross subsidised.

The QNMU also takes the opportunity to address *3.6 Teaching and training* (page 14 of the Consultation Paper) and ask that nursing and midwifery research be included in teaching and training activities.

How did the COVID-19 pandemic response impact activity and cost data in 2021–22, such as through significant events like lockdowns, and how should these impacts be accounted for in the NEP and National Efficient Cost Determinations for 2024–25?

We suggest that as part of assessing the impact of COVID-19 on the 2021-22 cost data, is the need to factor into the NEP the cost of planning and preparing for future pandemics with the aim of ensuring a more resilient health care system for the next pandemic.

For NEP24, what evidence is available regarding the clinical management of patients with a COVID-19 diagnosis, including patients in an ICU, to support retention of the:

- COVID-19 treatment adjustment
- temporary ICU measure for COVID-19 patients
- temporary HAC and AHR measures for COVID-19 patients?

The QNMU is supportive of the retention of COVID-19 measures as Australia continues to see thousands of COVID-19 positive cases being recorded every week. While the number of COVID-19 cases in hospital and ICU have decreased since the peak of COVID-19 cases in mid to late 2021, there are still patients requiring hospitalisation and invasive ventilations (Department of Health and Aged Care, 2023).

To inform the review of the ICU adjustment:

- what available evidence demonstrates the underlying drivers of cost variation for complex ICUs?
- what additional or alternative measures, other than mechanical ventilation hours, should IHACPA consider for inclusion in the eligibility criteria for a specified ICU?

The QNMU has no comment.

To inform the review of the paediatric adjustment:

- what available evidence demonstrates the underlying drivers of cost variation between specialised and non-specialised children's hospitals?
- what additional or alternative measures should IHACPA consider for inclusion in the eligibility criteria for a specialised children's hospital?

The QNMU has no comment.

To inform the NEP indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the delivery of Australian public hospital services? Additionally, what are the underlying drivers of cost growth contributing to these cost increases?

As identified by IHACPA in the Consultation Paper, there are increasing input costs that are growing at a faster rate than what is reflected in the available historical cost data. We acknowledge IHACPA's approach and concur that any indexation needs to be responsive and reflect the current situation so there is not a gap between the actual cost and funding.

What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations?

The QNMU suggests in considering price harmonisation for chemotherapy and dialysis that there are situations where it is clinically appropriate for patients to be admitted. For example, patients who live in rural and remote areas and travel to metropolitan areas for dialysis or chemotherapy, rather than having to travel to return home after treatment that they be admitted to hospital. Ensuring price harmonisation is considered not only through a metropolitan lens but all locations is necessary for this health service.

Additional analysis should also include the practice of patients being discharged from a hospital ward, admitted to a day procedure unit to receive their chemotherapy treatment, and then re-admitted back to the ward, thereby increasing the number of episodes of care and Commonwealth funding.

Are there any other public hospital services that are potential candidates for price weight harmonisation across settings?

The QNMU does not have specific public hospital services to offer for price harmonisation. However, the implementation of price harmonisation should be to facilitate best practice care in the most appropriate care setting. The implementation must also be clear in its intent – is it to drive down costs or to lift the standard of care? As such, financial incentives should drive outcomes-based and person-centred care.

To inform the NEC indexation methodology review, what alternative indices or metrics are publicly available and applicable at a national level, that demonstrate an evidence-based correlation between price inflation and cost increases in the expenditure of small rural hospitals, specialist metropolitan hospitals or block-funded services? Additionally, what are the underlying drivers of cost growth unique to these services?

As noted in the Consultation Paper, the cost pressures faced by regional and remote hospitals include workforce shortages. The recent Queensland Government announcement of a workforce attraction scheme to incentivise interstate health workers to move to Queensland

highlights the lengths being taken in addressing workforce shortages (Queensland Government, 2023). How this will impact the cost and price of hospital and health services will need to be monitored. Other cost pressures associated with workforce issues include relocation costs for staff who move to be where the work is, and the housing crisis currently being experienced throughout Australia where rental accommodation may not be available or at an inflated cost.

As stated in previous years in our submissions to IHACPA, the QNMU continues to recognise transport costs to have medical supplies, consumables and food transported from metropolitan areas to rural and remote areas.

What assurance approaches should IHACPA consider, to ensure NHCDC data is prepared in line with the AHPCS, and that would reduce duplication of data reporting for states and territories?

The QNMU reaffirms the need for data collection to be undertaken by the relevant government agency and not outsourced, to enable and ensure greater data transparency and accountability.

Given virtual care is a broad and evolving space, what specific areas and care streams where virtual care is being delivered should IHACPA prioritise for further investigation to inform future data collection, classification and pricing refinement?

The QNMU supports IHACPA in continuing to investigate where virtual care is being delivered and the data collection, classification and pricing that is required. Virtual care allows patients to connect with health practitioners to deliver care when and where it is needed. As discussed in previous submissions to IHACPA, we continue to advocate for virtual models of care, in particular nurse-led and midwife-led including these:

- *Virtual emergency department* model where patients needing urgent non-life-threatening care by telehealth and are initially seen by an experienced emergency nurse and then a doctor (Queensland Government, 2022a).
- *Virtual model of chronic disease management* which provide programs on diabetes, heart failure, cardiac rehabilitation and pulmonary rehabilitation by a range of health practitioners (Smithson, Roche & Wicker, 2021).
- *Hospital in the home* (HITH) *service* is a hospital avoidance strategy implemented to treat and monitor patients in the home with services offered by nurses and other health practitioners (Queensland Government, 2022b).
- *13HEALTH* is telephone triage where RNs can assess symptoms and provide health advice to those seeking health information using a range of protocols to guide the triaging process (Queensland Government, 2020).

- *Mental health co-responder program* where those in mental health crises are assessed in the community by a mental health nurse with a QAS paramedic rather than taking them to hospital (as previously discussed in this submission).
- *Walk-in centres* (WiC) operate across Canberra, Australian Capital Territory. The service is free, and no appointment is necessary and are staffed by RNs and Nurse Practitioners where they provide free health care advice and treatment for non-life-threatening injuries or illnesses thereby taking the pressure off emergency departments (ACT Government, 2023).
- *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. (Queensland Nurses and Midwives' Union, 2020).

Do jurisdictions have the capacity to submit cost data for activity reported under the emergency care virtual care data specifications?

- No comment.

Do you have any further comments to inform the development of the NEP and NEC Determinations for 2024–25?

As outlined in the National Health Reform Agreement Addendum 2020-25, IHACPA's role in determining adjustments to the national efficient price is to have "regard for legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery" including patient complexity and Indigenous status (2020, p.22). The QNMU sees public hospital funding, as an important funding function for better healthcare outcomes for First Nations people.

References

Australasian College for Emergency Medicine. (2022). *State of emergency 2022*. Retrieved from https://acem.org.au/getmedia/81b2f4f8-c0f2-46a0-86c1-64b7d1d311c2/State-of-Emergency-D32-MSTC

ACT Government. (2023). *Walk-in Centres (WiC).* Retrieved from https://www.canberrahealthservices.act.gov.au/services-and-clinics/services/walk-in-centres-wic

Australian Government. (2020). *2020–25 National Health Reform Agreement* (NHRA). Retrieved from https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra

Department of Health and Aged Care. (2023). *Weekly COVID-19 reporting*. Retrieved from https://www.health.gov.au/health-alerts/covid-19/weekly-reporting?language=und

Queensland Government. (2023a). *Clinicians hit the road as part of the Mental Health Co-Responder Model Wednesday 12 April 2023*. Retrieved from https://www.health.qld.gov.au/widebay/publications/news-articles/clinicians-hit-the-road-as-part-of-the-mental-health-co-responder-model

Queensland Government. (2020). *13 HEALTH. Health advice over the phone*. Retrieved from https://www.qld.gov.au/health/contacts/advice/13health

Queensland Government. (2023b*). Palaszczuk Government delivers additional investment to attract health workers.* Retrieved from https://statements.qld.gov.au/statements/97709

Queensland Government. (2022a). *Successful health service expanded to all Queenslanders*. Retrieved from https://statements.qld.gov.au/statements/96436

Queensland Government. (2022b). *Understanding HITH*. Retrieved from https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/care4qld-strategy/hospital-home/understanding-hith

Queensland Nurses and Midwives' Union. (2020). *Nurses and midwives EB10 innovation fund project. Project summary. Nurses and midwives EB10*, clause 44.6.

Smithson, R., Roche, E. & Wicker, C. (2021). Virtual models of chronic disease management: lessons from the experiences of virtual care during the COVID-19 response. *Australian Health Review*, 45, 311-316.