Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

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Queensland Nurses & Midwives' Union

Submission to

Health and Environment Committee

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Health and Environment Committee (the Committee) for the opportunity to comment on *the Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*.

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 supports this inquiry into the provision of primary and allied health care, aged and NDIS care and private health and its impact on the public health system. Taking a broad view, Queensland's health care system sits within Australia's health system which is complex and disjointed - federal and state governments and private sector providers including primary health and aged and disability care providers all play different roles. Responsibility for health service planning and delivery is divided and collaboration is not incentivized. As a result, care is fragmented and costs are shifted, contributing further to system dysfunctionality. In addition to this fragmentation is the added complexity on how to navigate care, particularly for those with complex health care needs. We believe there is a need for a greater focus on joint planning and funding between the state and federal governments to meet the population's health care needs and to deliver safe and quality health care for all. The QNMU is calling on both the federal and state governments to address the health care system to meet the needs of Queenslanders in the short, medium and long-term.

In our submission to Queensland Health on expanding health care quality and patient safety reporting across Queensland's health care system (2017) we first raised the concept of establishing a Health Performance Commission. We see this as an overarching, independent body to gather, analyse and report on data that enables value-based health care. It would be well placed to link hospital and health data with other economic and social data as an evidence base for value-based health care and new health programs. Given the divided roles and responsibilities for health and health care that involve different levels of government we

suggest that if the Health Performance Commission was established, it could facilitate greater integration and coordination of health care services and resources between government sectors.

This inquiry comes at a time when the demand for health services in Queensland is exceeding supply with an urgent need for additional investment in Queensland's health system. In response to this need, the QNMU, together with other health workers and their unions, launched the campaign – *Health Needs Urgent Care*, (2021a) (the campaign) calling for immediate and long-term solutions to fix the problems of Queensland's health care system. Even before the COVID-19 pandemic, there were increasing demands on already stretched health services and beds that were impacting QNMU members and other health staff. With the Queensland border re-opened and with the potential Omicron strain being more virulent than Delta we fear the anticipated surge in Queensland of COVID-19 cases will have enormous impacts on an already understaffed and under resourced workforce – and our ability to provide quality care. We see the disruption caused by COVID-19 to the health care system as a chance to reset and enact different models of care that increase a patient's access to healthcare, provides more choice and meets the needs of all who need to access it.

It is our view that health equity for all Queenslanders, where they have the opportunity to live their healthiest lives, is foundational to this inquiry. Equity not only in health but in health care. The social determinants of health, the conditions in which people are born, grow, live, work and age, influence health and wellbeing outcomes and quality of life. To achieve health equity, we believe greater coordination of federal and state government health services and programs is imperative. Aligning action through whole-of-government approaches will assist in making Australia more equitable. We acknowledge the work Queensland Health is already undertaking in this area, particularly with the First Nations Health Equity framework and we support more of this understanding of local, community health needs.

In framing our response, the QNMU will address the terms of reference and have included a number of case studies. We have also chosen to focus on several areas within Queensland's health care that are currently impacting health care delivery and/or are areas of the health care system we wish to address. They are:

- workforce planning;
- ambulance ramping;
- demand on emergency departments;
- mental health care;
- palliative care.

Recommendations

The QNMU recommends the Queensland Government:

- Support growth of innovative nursing and midwifery models that will enhance the ongoing sustainability and safety of our public health system.
- Review and extend new and/or improved models of care that were successfully implemented in response to COVID-19.
- Address nursing and midwifery workforce shortages through the development of a comprehensive health workforce plan for Queensland.
- Consult and include First Nations people in every stage of health care and delivery.
- Continue to support the use of multi-disciplinary teams within primary health care.
- Continue to implement models of care that focus on preventing illness and disease and promoting health and wellbeing.
- Trial and evaluate new models of funding that would complement activity-based funding.
- Review current funding and contracting arrangements of community organisations to ensure continuity of care and service.
- Support the federal government in implementing and achieving the recommendations from the Royal Commission into Aged Care Quality and Safety.
- Investigate funding for additional mental health community-based extended-services.
- When allocating funding for mental health services, provide a commitment that this funding will continue, ensuring continuity of mental health services and care.

1.a. The provision of primary and allied health care and any impacts the availability and accessibility of these services have on the Queensland public health system

Ensuring access to primary and allied health care is key to improving health outcomes, so in addressing this term of reference, the QNMU has chosen to focus on:

- state-specific considerations;
- innovative health care;
- multidisciplinary collaboration;
- funding reform;
- nurse-led models of care;
- midwife-led models of care;
- examples of initiatives supported by the QNMU.

One arm of Queensland's health care system are the services provided by the primary and allied health sectors. The QNMU takes the position that primary health care is a broad range

of health services that includes services provided by nurses and midwives and allied health practitioners. The Alma-Ata Declaration of 1978 identified primary health care as the key to the attainment of the goal of health for all and is the first element of a continuing health care process that brings health care as close as possible to where people live and work (World Health Organization, 1978). We strongly support this view and believe that quality primary health care is associated with increased access to services, better problem recognition and diagnostic accuracy, a reduction in avoidable hospitalization, better health outcomes, lower suicide rates, and a higher life expectancy (World Health Organization, 2018).

State-specific considerations

When discussing the accessibility to health care in Queensland, the state's demographics and geographically diverse population is an obvious consideration. Covering just over 95% of the state's land mass, rural and remote Queensland is home to over 1.65 million people (Queensland Government, 2016). Due to their geographic location, low population density, limited infrastructure, and higher costs for delivering health care in rural and remote areas, people living in rural and remote areas experience challenges in accessing health care more so than those who live in urban centres (Australian Institute of Health and Welfare, 2018). Many must travel significant distances, often at great cost and inconvenience to seek health care.

Another state-specific consideration is that for some, primary and allied health care is not easily available or accessible. This is evident for First Nations people where barriers to accessing health care include cost, experiences of discrimination, and poor communication with health care practitioners. This has impacted the health and life expectancy of First Nations people identified in the *Closing the Gap Report 2020* where there has been limited progress against the life expectancy target[1]. Delivering culturally sensitive primary health care must be appropriate to the unique culture, language and circumstances of First Nations people.

A recent example of poor accessibility was the initial slow COVID-19 vaccination programs rolled out to First Nations people in rural and remote parts of Queensland leading to low vaccination rates in these communities. Initial criticism was levelled at the low number of Indigenous-specific outreach programs to undertake this work. To ensue clinics are culturally welcoming, First Nations people must be engaged with to ensure culturally sensitive health care provision. This is not only imperative for the vaccination programs in rural and remote areas but health care as a whole.

[1] The target to close the gap in life expectancy by 2031 is not on track. In 2015–2017, life expectancy at birth was 71.6 years for Indigenous males (8.6 years less than non-Indigenous males) and 75.6 years for Indigenous females (7.8 years less than non-Indigenous females). Over the period 2006 to 2018, there was an improvement of almost 10 per cent in Indigenous age-standardised mortality rates. However, non-Indigenous mortality rates improved at a similar rate, so the gap has not narrowed.

Equity of health outcomes for Queensland's First Nations people is a priority. It can only be achieved when First Nations people are consulted and considered in every stage of health care and delivery to ensure it is culturally safe, responsive and is evidence-based. A step to achieve this may be to improve the cultural safety of mainstream services to First Nations people by providing cultural safety training for health staff. Research shows when health care systems improve cultural safety practice, patient experiences of communication, patient satisfaction and trust improve (De Zilva, Walker, Palermo & Brimblecombe, 2021).

Innovative health care

In addressing ways to access primary health care, we need look no further than the federal and state government's response to the outbreak of the COVID-19 virus. These events have highlighted there is very little excess capacity in the health care system to meet the needs of an ageing population, an increasing prevalence of illness and disease alongside chronic conditions when emergent events such as a pandemic, occur. COVID-19 has prompted a welcomed review of the broader health care system, how it is accessed, the health care workforce and the roles each health practitioner plays. The COVID-19 crisis has been a stark reminder that our health care system must meet patient needs, be responsive as well as being sustainable.

The pandemic has forced governments and health care providers to consider alternative ways in delivering health care and adapt and develop strategies in surge capability. Changes to state legislation, as well as regulatory and policy frameworks have enabled an agile response in introducing and adapting models of care and service provisions. The following innovative models have been either implemented or further developed during the pandemic response:

- virtual care which improves access and convenience for patients. E.g., virtual diabetes clinics;
- hospital in the home (HITH) - a hospital avoidance strategy implemented to treat and monitor patients in the home;
- triaging models and assessment tools such as in-car triage/fever clinics and open-air consultations where patients arrive in their car, drive-through to where nurses take swabs, from which the sample is sent for COVID-19 testing;
- telehealth;
- 13Health – health advice provided by RNs over the phone; and
- testing and fever and vaccination pop-up clinics.

These strategies demonstrate that by challenging the status quo of how primary health care is delivered, alternatives to service delivery can be found that increase accessibility, are patient-centred, effective, lower-cost, and reduce the demand on hospitals. We urge the state government to urgently evaluate the value and outcomes of changes adopted during the pandemic with the view that those practices that work effectively be retained as regular practice.

We believe this aligns with a recommendation made by the Queensland Audit Office (2021b, p.3) where they identified that to improve access to specialist outpatient services, Queensland Health must 'work with hospital and health services to embed proven, innovative models of care and more integrated health solutions across the state to help increase capacity and optimise benefits more broadly'. The QNMU supports the rigorous evaluation of these models of care to provide evidence of their effectiveness for the patient and the greater health care system.

In addition, it is the view of the QNMU that a shift is required in the dominant short-term focus of treating illness and disease, which contributes to the undermining of the long-term sustainability of the health care system. The QNMU believes there is insufficient attention paid by governments to advancing innovative models of care that focus on what matters most – protecting and preventing illness and disease and keeping people out of expensive acute care hospitals. Chronic conditions make up roughly half of all potentially preventable hospitalisations (46%) which in 2015-16 cost the Australian health care system over $2.3 billion (Australian Institute of Health and Welfare, 2020). Further approaches need to be developed that look at health promotion and wellbeing and secondary prevention activities such as social prescribing. Prevention and intervention will not only reduce the pressure on the health budget, but it will also increase workforce participation and productivity and improve the health of future generations.

Multidisciplinary collaboration

The QNMU believes that an essential component in delivering primary health care is through multidisciplinary teams, working together to improve health outcomes for patients and reduce the strain on the wider health care system. Health practitioners from a range of health disciplines and with varied skill mixes deliver comprehensive, coordinated primary health care with significant benefits that include:

- reduced emergency department visits;
- reduced hospital admissions and readmissions;
- reduced inappropriate healthcare interventions;
- reduced duplication of services;
- care that is better aligned to patient and family needs;
- care that is collaborative;
- decreased total health spending;
- a healthier, more supported population (Agency for Clinical Innovation, 2021).

Multidisciplinary teams that include nurses and midwives, are a critical component in Queensland's broader health care system as these multidisciplinary teams are able to support patients in their health care and prioritise and identify care goals, take into consideration the patient's cultural preferences and stage of life, across a wide range of concerns such as mental

and physical, chronic and acute, intervention and prevention, rehabilitation and palliative care (World Health Organization, 2018).

We acknowledge, however, that there is no one-size-fits-all approach as to the occupations of health practitioners that form the multidisciplinary team. The makeup of the multidisciplinary team is determined by workforce planning, retention, recruitment and availability of health practitioners, patient complexity and needs, funding models and the geographic location of the primary health care facility. Some of these issues we will address later in our submission.

To support multidisciplinary teams in becoming highly functioning and effective, there are internal and external mechanisms that can shape the practice of these primary health care teams. Internal factors such as a culture of support, a shared purpose and recognition of the important role each health practitioner plays, support for power sharing, joint problem-solving and building mutual respect are integral to multidisciplinary teams working effectively and providing safe and quality care.

Funding reform

Another impact that effects the availability and accessibility to primary health care is how it is funded. The QNMU believes there is an urgent need to reframe funding by focusing on the value of the provision of health care rather than on activity undertaken. The QNMU strongly believes that if primary health care is provided by nurses and midwives and allied health practitioners within their scope of practice, then this must be reflected in funding. That the Medicare Benefits Schedule (MBS) funding model continues to prescribe that health practitioners within the multidisciplinary team are deemed to have provided care 'for and on behalf' of a medical practitioner, diminishes and limits the important role they play in delivering primary health care.

Nurse-led models of care

Research shows that nurse-led and midwife-led models of care do not dilute access to or quality of primary health care services but strengthens the provision and access to primary health care and have:

- improved access to healthcare services, particularly in rural and remote areas;
- provided co-ordinated care across acute and community boundaries;
- improved continuity of care by acting as a link between primary health care services and other health service providers;
- increased early intervention of health issues through building a rapport with the patient and community;
- reduced avoidable emergency department/hospital admissions and ambulance trips, (Douglas, Schmalkuche, Nizette, Yates & Bonner, 2018 & KPMG, 2018).

There are many roles and models of care occupied by ENs, RNs and nurse practitioners (NPs) working in primary health care. They include:

- immunisation services where RNs administer vaccines with a medical practitioner's written or oral order;
- providing mental health care for people experiencing mental health issues;
- diabetes nurse educators who support patients in the management of their diabetes;
- sexual and reproductive health care that includes taking sexual and reproductive histories, screening for sexually transmitted infections, contact tracing, and providing information and education to patients;
- nurse clinics where nurses within their scope of practice are the primary provider of care and examples of these clinics include:
    - women's health;
    - lifestyle medication (e.g., weight loss, smoking cessation); and
    - wound management (Australian College of Nursing, 2015).

And yet, some nurse-led and midwife-led services continue to be contested in a medically dominated healthcare system. These models of care are often only supported when under the direction and supervision of medical practitioners with the level of autonomy in clinical practice often controlled by medical colleagues, thereby diminishing the critical role nurses and midwives play (Douglas, Schmalkuche, Nizette, Yates & Bonner, 2018).

However, there are also many success stories where nurses and midwives have been supported in developing and implementing innovative models of care in particular nurse navigators and nurse practitioners.

Nurse navigators

Nurse navigators are advanced practice RNs who deliver nurse-led models of care. Nurse navigation models deliver person-centred care co-ordination, create partnerships with patients and with and between stakeholders in patient care, improve patient outcomes and facilitate system improvements. (Hannan-Jones, Mitchell & Mutch, 2021). Queensland Health introduced nurse navigation in 2016 as part of a wider health care reform agenda to address the fragmentation of the health care being delivered, to assist patients with co-ordinating their care and to keep them well and out of hospital. Their boundary-spanning role enables them to engage across and beyond primary and secondary health care settings (Hannan-Jones, Young, Mitchell & Mutch, 2019).

Preliminary reports of the benefits of the nurse navigator in Queensland are extremely encouraging with the Torres and Cape Hospital and Health Service (TCHHS) showing a 61% decrease in visits to emergency departments (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, 2019b).

The disability nurse navigator was also rolled out at this time and provides a person-centred approach for those living with a disability and frequently intersects with the National Disability Insurance Scheme (NDIA) in an advocacy capacity. These nurses were particularly important when there was rapid service change due to COVID-19 which saw those with disability having to use telehealth. The disability nurse navigator was able to stabilise the relationships between changed service provision and the capacity of people with disability to use this technology (Brunelli, Beggs & Ehrlich, 2021).

Nurse practitioners

NPs are experienced RNs educated to Masters level and competent to function autonomously and collaboratively in an expanded clinical position. NPs have access to the MBS and Pharmaceutical Benefits Scheme (PBS) and provide high levels of clinically focused autonomous nursing care. KPMG (2018) for the Department of Health, conducted a cost benefit analysis of NP models of care in aged care and primary health care in Australia. They identified that for NPs to be effective they should not be regarded as a substitute for general practitioners (GPs) but rather as an opportunity for meeting unmet needs and were seen as valuable particularly in rural and remote areas and residential aged care facilities.

One example of a nurse-led model of care that gained the support from hospital executive and other health practitioners is the *Nurse Practitioner (NP) in Breast Oncology* (2021b). The NP helped establish this service that provides breast care services as part of a multi-disciplinary team for those patients being treated for breast cancer. Anecdotal evidence is already showing the service is receiving positive feedback and patient numbers increasing.

In a recent Australian study (Wilson, Hanson, Tori & Perrin, 2021) one successful NP-led model of care saw NPs provide after-hours urgent care for rural communities. The after-hours NP roles emerged as multi-faceted, able to use their advanced clinical skills and provide holistic care in rural communities. Utilising NPs in primary health care in rural communities will alleviate the burden on GPs and hospital services and contribute to primary health care access for all.

Furthermore, is the successful and cost-effective NP/advanced practice nurses' model in the Australian Capital Territory (ACT) called *Walk-in Centres* which is a network of nurse-led clinics. Nurses provide free health care advice and treatment for non-life threatening injuries or illnesses thereby taking the pressure off emergency departments. These nurse-led models of care undertake comprehensive assessment, provide timely person-centred care, opportunistic education and support, continuity of care and link patients to other health professionals and services.

Midwife-led models of care

The QNMU believes women should have access to professional midwifery care, regardless of where they live in Queensland. Midwife-led models of care are an important part of primary health care. The World Health Organization (2013) has strongly supported midwife-led continuity of care models for pregnant women and view these models as being beneficial for the woman and her family. These midwifery services need to be adequately funded, staffed and supported. We encourage the government to incentivise maternity service models in which women receive continuity of care from a known midwife throughout their pregnancy, during birth and after the birth. These models have been shown to produce physical benefits for mothers and babies and are cost effective (Callander, Slavin, Gamble, Creedy & Brittain, 2021).

The QNMU's *Count the Babies* campaign continues to highlight the very real concerns that under commonwealth legislation (the *National Health Act 1953* and the *Health Insurance Act 1973*) mothers, and babies under 9 days, are considered one person despite the level of care and documentation specific to the newborn. (Babies younger than 9 days of age are considered "unqualified neonates" for Commonwealth funding, including not be recognised under the activity based funding (ABF) regime.) This impacts a midwife's workload dramatically and their ability to provide safe, quality care.

We also strongly assert that birth on country models are examples of best practice. An example is the *Waijungbah – Innovation: Integration of birthing on country and first 1000 days Australia models of care*. The Gold Coast HHS in collaboration with the Gold Coast Aboriginal and Torres Strait Islander community, provide continuity of care by a First Nations midwife and child health nurse from conception to the first 1000 days. Birthing on Country and the First 1000 Days Australia principles are both aimed at providing Aboriginal and Torres Strait Islander babies with the best possible start in life. An evaluation of the outcomes of the model of care has shown that most mothers have had a culturally safe experience and had better clinical outcomes than women in standard care. Further, mothers were reporting the interaction, engagement and relationship between them and the midwife was a valuable and important aspect of the model (Queensland Health, 2020).

Another example of a midwifery-led model of care is the *Midwifery Community Access Program* at the Townsville HHS. This program is about ensuring pregnant women in the community can access antenatal care early and regularly, rather than just when they give birth. It provides culturally safe care and increases access for First Nations women to a Clinical Midwife Consultant It aims to reduce discharge against medical advice, failure to attend antenatal appointments and reduce high levels of smoking during pregnancy. This improves health outcomes for First Nations women and their families. (Queensland Nurses and Midwives' Union, 2020).

The QNMU also supports the permanent amendment of Section 19(2) of the *Health Insurance Act 1973.* (This section prohibits the payment of Medicare benefits where other government funding is provided to that service. In the past, the Council of Australian Governments (COAG) has approved the introduction of a Section 19(2) exemption initiative that has been extended over time to enable exempted eligible sites (most in Queensland being in regional or remote areas) to claim against the MBS for non-admitted, non-referred professional services (including nursing, midwifery, allied health and dental services). We believe this exemption should be extended to include other regional and metropolitan sites to support the delivery of innovative models of care. We see this as critical in increasing access to primary health care for all small rural and remote communities' and enhancing service delivery to these areas. We would also like to see any extension of the 19(2) exemptions for primary health services, includes midwives which would enable midwives with an endorsement to work in primary health centres to provide community-based midwifery care.

Examples of initiatives supported by the QNMU

When discussing nurse-led and midwife-led models of care, it is with pride that the QNMU promotes the often-unnoticed work that nurses and midwives are undertaking in reshaping health care services to improve patient experience and address gaps in health services. We strongly assert that expanding nurse and midwife-led services has the potential to create a more accessible, productive, and safe healthcare system in Queensland.

The QNMU takes the opportunity to acknowledge the benefits of the establishment of the $10 million Innovation Fund under the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10)*. This has meant that Queensland Health has made this money available through EB10 with the support of the QNMU. In September 2019, 19 projects were funded. They are:

- *Waijungbah - Innovation: Integration of birthing on Country and first 1000 days Australia models of care*;
    - discussed previously in our submission.
- *Gold Coast Mental Health and Specialist Service (GCMHSS) and Gold Coast Local Ambulance Service Network (GCLASN) Co Responder Model of Service*
    - the project has enhanced two existing models in the GCHHS, the *Coordination Hub Initiative* and the *Gold Coast Mental Health and Specialist Service/QPS Co Responder*. Early findings show hospital avoidance between 45-58%, reduced length of stay for those that required hospital intervention via the emergency department and less use of restrictive practices e.g., use of *Public Health Act (2005)* and *Mental Health Act (2016).*
- *Maximising scope of practice: Mental Health Nurse Practitioners addressing community clinical complexity and unmet customer need*
    - the project expanded the Sunshine Coast University Hospital Mental Health Nurse Practitioner (MHNP) Emergency Department model of care into MHNP

community roles. Early findings show 41% of hospital avoidance interventions occurred after-hours and 460 interventions specifically for clinical deterioration, secondary consultation and medication intervention for mental health patients.

- *Nurse Practitioner Innovation Project*
    - the project created two NP positions within the Outer Islands of the Torres and Cape Hospital and Health Service. The NPs are responsible for providing support, leadership and clinical expertise in remote area nursing practices complementing existing services. Early findings show remote area nurses are feeling valued and supported.
- *Community Maternity Hubs Model*
    - targets the social determinants of health in the Logan community and addresses the needs of mothers, babies and children. Early findings show an increase in antenatal attendance and higher breast feeding rates.
- *Shared Care for Opioid Treatment (SCOT) Project*
    - the project increases access to opioid treatment programs for the vulnerable and complex population moving in and out of correctional facilities and other people experiencing opioid dependence in the community. Early findings show engaging nurses in developing the shared care model has increased the focus on client recovery.
- *Child Development Clinical Nurse Consultant (CNC)*
    - introduced in the Darling Downs district to address the large cohort of triage category three patients on the paediatric or child development service waiting list with behavioural concerns. Early findings from the trial saw more timely care (including early access to specialised services for rural clients and improved access for vulnerable patients on a medical waitlist) and high engagement from many eligible patients across the four centres.
- *Trauma Informed Care*
    - aims to provide the mental health nursing profession with a model of care to complement current practice and reinforce a person-centred approach and acknowledging the prevalence of trauma. Early findings show that a 4 hour education package was delivered to 416 health practitioners across Metro North mental health with feedback indicating it was informative and relevant.
- *Enhanced General Practice STI Testing Initiative*;
    - the project was a collaboration with multiple high Aboriginal and Torres Strait Islander caseload General Practitioner (GP) services in Townsville HHS to build capacity to increase opportunistic Sexually Transmitted Infections (STI) testing rates in response to the current syphilis outbreak amongst the population. Early findings show one GP service has shown sustained, above average syphilis testing.
- *Pregnancy on Palm* (PoP)

  - this project implemented and evaluated a phone application (app) to provide information to women and increase communication between maternity service staff and pregnant and post-natal women within the Palm Island community. Early findings show strong community engagement with the app.
- *Transition framework from paediatric to adult health care*
  - the aim of this project is to develop a framework that is transferable across Queensland to guide the timely, planned process of transition for adolescents and young adults with chronic conditions from the paediatric to adult healthcare setting. Early findings show improved patient experience and greater continuity of care.
- *Healing Wounds - Building Lives - a collaborative wound care capacity building project*
  - the project has developed and implemented a nurse-led model of wound care that can be applied across all health settings. Early findings show that staff have reported an increase in their wound care knowledge.
- *Routine Preventative Cancer Screening – Prison Health Services*
  - the program was about ensuring incarcerated men and women received access to preventative screenings for bowel and breast cancer. Early findings show an increase in bowel cancer screening participation.
- *Enhanced Aboriginal and Torres Strait Islander Infant and Maternal Care*
  - the vision for the project was to prevent adverse outcomes for mothers and babies that were disengaging from obstetric clinics and clinically at higher risk of morbidity and mortality. Early results from the project saw mothers consistently attending antenatal visits.
- *ReViving Rural Dementia Care*
  - the project aimed to empower the Cairns and Hinterland HHS rural facilities with knowledge, improved environments and additional resources to provide best practice care to dementia in the local community. Early findings show that the development of dementia resources has increased understanding of dementia.
- *Improving Access for Displaced Patients*
  - the aim of this project is for NPs to improve service access and efficiency for acute care patients with a prolonged time to be seen by a treating clinician in the emergency department. Early findings show that median wait time was reduced, and increased discharge rates.
- *Digital Back to Country*
  - this project saw health practitioners and patients connected by means of a wearable device to wear at home. Early findings show that this model of care has enabled patients to receive care in the home which reduces costs and frees up hospital beds.
- *Midwifery Community Access Program*
  - discussed previously in our submission.

- *Nurse Navigator Refugee Health*
    - the Nurse Navigator role acts as a central contact for hospital staff and general practices to coordinate care, liaise and assist with language and cultural barriers when refugees access Toowoomba Hospital services and provide education on refugee health. From October 2019 - August 2020, the Nurse Navigator was contacted 1110 times for both patient related assistance and for general enquiries regarding refugee health.

These projects were funded for one year and have produced tangible results that not only improved clinical outcomes and patient experiences but positively addressed the social determinants of health. These projects also highlight the significant gaps that currently exist between acute care services and community based non-acute care services and the role that nurses' and midwives are so well positioned to play in bridging these gap. These gaps exist in large part because of the fragmented funding and policy frameworks that exist at the federal and state levels of government.

1.b. The provision of aged and NDIS care and any impacts the availability and accessibility of these services have on the Queensland public health system

It should go without saying that any person with a disability and those who require aged care, must have comparable access to health care as in the acute health care sector. This would ensure residents and/or patients can receive care that is convenient for them and would greatly reduce the impact on Queensland's public health system as those receiving disability and aged care, would do so in the place of their care rather than in acute care settings. And yet, sadly, this has not always been the case. The stark findings from the recent *Royal Commission into Aged Care Quality and Safety* (Aged Care Royal Commission) and the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Disability Royal Commission) have shown that for many who are seeking support from the disability and aged care sectors, they have received poor, substandard health care and experienced neglect. We believe the opportunity is overdue in providing the care that is needed in the disability and aged care sectors.

In supporting the ongoing provision and sustainability of aged care and NDIS care in Queensland, it is particularly important to address the key issues and drivers of the current systems. We acknowledge there are strong parallels between the disability sector and the aged care sector, in terms of service quality and delivery, workforce and market forces and funding. We will now address aspects of aged care and the NDIS and the role they play in Queensland's health care system.

Aged care

We applaud the state governments' commitment to minimum nurse to patient/resident staffing ratios which has seen legislation passed making nurse-to-resident ratios law in

Queensland's government-run aged care facilities. This maintains minimum aged care staffing and skill mix and reduces unwarranted variation in service safety and quality in aged care. The benefits of ratios are many with research within the aged sector and beyond the sector showing minimum staffing levels and skill mix are critical in delivering safe, quality care (Peters, Marnie & Butler, 2021 & McHugh, Aitken, Windsor, Douglas & Yates, 2020). The QNMU has been working with the Office of the Chief Nursing and Midwifery Officer (OCNMO) in undertaking the evaluation of Queensland's public aged care sector with the outcomes of this work yet to be completed.

Whilst ratios are a great achievement for Queensland's public aged care sector and recipients of that care, the QNMU continues to advocate for nurse-to-resident ratios in private aged care facilities. That privately owned aged care facilities do not have mandated minimum ratios in place, continues to diminish and deny the health care needs of those who live in these facilities.

The QNMU believes the current residential aged care workforce, comprised primarily of unregulated care workers, lacks the training and skills needed to adequately meet the care needs of this special needs group. The situation is compounded by the overall decreasing number of RNs and ENs employed in aged care which is resulting in the de-skilling of the workforce. Missed care due to inadequate staffing and skill mix means that residents are not receiving basic care needs in a timely manner putting them at greater risk of falls, pressure injuries and nutrition deficits. A distressing example is the coronial inquest into the deaths of 50 residents at St Basil's aged are facility in Melbourne where 45 residents died from COVID-19 while a further 5 dying from neglect. Gaps in infection control were revealed when the entire St Basil's staff were classified as close contacts and told to quarantine and an agency relief workforce brought in. The inquest has heard that the federal government struggled to find replacement workers due to other COVID-19 outbreaks with residents reportedly missing meals, medications and activities of daily living care, leading to neglect and deaths. This highlights not only the workforce shortage issues in health and aged care but the importance of the right skill mix of the staff who work in residential aged care facilities.

The QNMU also has significant concern with the new Queensland regulatory framework for medicines and poisons that came into effect at the end of September 2021. This new framework, *Medicines and Poisons (Medicines) Regulation 2021,* replaces the *Health (Drugs and Poisons) Regulation 1996 (Qld*). It is extremely disappointing that the new framework does not address the ambiguity around what constitutes medication assistance and how unregulated care workers are regulated under this framework. For the safety of those receiving medications we believe medication management and medication administration is a role for nurses and midwives, with unregulated care workers restricted to medication assistance.

The recent federal government announcement of the membership of the new *National Aged Care Advisory Council*, tasked with providing expert advice and guidance on aged care, has been formed without any nursing groups represented. This blatant oversight is mystifying and goes against the findings and recommendations of the Aged Care Royal Commission and the need for high quality aged care. It begs the question, how can high quality aged care be developed and planned if nurses aren't represented? This short-sightedness impacts not only the type of care delivered to those who live in aged care facilities, it places a strain on an already crowded health care system. While this is a federal government decision, it highlights how the federal and states systems are intertwined with decisions made at one level of government, having significant impacts at local levels.

There appears to be a widespread view that aged care, particularly residential care, is not health care despite the significant, and increasing, health care needs of residents. The QNMU believes all residential aged care services should be classified as health services, irrespective of how else they are categorised. Residential aged care facilities must be able to provide acute care to those residents who need it and be able to access services such as telehealth and virtual care to avoid unnecessary transfers of residents to hospitals. This lack of acknowledgement of aged care as a health service means aged care providers have little incentive to invest in hospital avoidance processes such as primary care and on-site clinical (nursing, medical and allied health) interventions. We believe hospital avoidance is best achieved by having the right staff with the right skills and the right support to ensure timely treatment can be provided in the residential aged care facility. This will then have the potential to reduce unnecessary harm and distress caused to residents by avoidable hospitalisation.

The QNMU believes the state government has a critical role to play in holding the federal government to account for the timely implementation of all recommendations from the Aged Care Royal Commission. If the federal government does not accept this responsibility, then it will fall to state and territory governments to "fill the gap". We need look no further than the experience a few years ago with the Queensland government being forced to take over the running of the Earle Haven aged care facility on the Gold Coast. It is our belief that other residential aged care facilities are experiencing financial and or staffing shortages and as a result the Queensland government will be called upon to act to provide these services in the local affected communities. It is not technically their responsibility to do so, but such systems failures demand urgent action and unfortunately given Queensland Health is all too often the major health service provided in many communities in Queensland, it will fall to Queensland Health to fill the void.

If the federal government, as funder and regulator, continues to fail to take responsibility, the impact on Queensland's public health system will be immense as it tries to deal with an increasing and ageing population, coupled with growing health care needs. Therefore, states

and territories must support the federal government to achieve the recommendations proposed by the Aged Care Royal Commission to:

- look beyond individual programs and arrangements of integrated long-term support to focus on what older people want and need;
- integrate health and aged care systems, thereby delivering the best outcomes for older people;
- ensure the care finders employed to support the navigation of aged care are suitability trained and qualified;
- ensure aids and equipment programs are adequate and accessible for all who need it;
- publicly report, each quarter, the status of the waiting list to receive the Home Care Package;
- share data about the different types of services across Australia, potentially establishing benchmarks or standards for particular areas across both public and private aged care providers;
- establish culturally appropriate documents such as advance care directive processes;
- make available vocational educational training facilities, teachers and courses in urban, rural, regional and remote Australia to assist in the employment and training for First Nations people in aged care (Royal Commission into Aged Care Quality and Safety, 2021a);
- mandate that a RN must be available 24/7 in nursing homes to prevent adverse outcomes and costly hospital interventions;
- grow the skilled workforce required in aged care through the vocational education and training sector.

This is by no means an exhaustive list, but it illustrates the work states and territories need to undertake in the aged care sector as identified by the Aged Care Royal Commission.

It is our view, providers of aged care must not only be held accountable for the health, wellbeing, and safety of those in their care but how they spend government funding. Currently, the federal government does not require aged care providers to report on care needs and the care expenditure. There is no obligation or regulation that requires them to do so. The QNMU believes this must change to provide an oversight of how the financial arrangements of aged care providers and home care providers are structured and how the bulk of their funding, which comes from the public purse, is spent.

We provide two examples to illustrate how poor regulation of financial arrangements leads to unaccounted funds and unaccounted care. One is related to residential aged care providers and another concerns home care providers:

- In the financial year (2016-2017) six for-profit aged care companies combined received over $2.17 billion in government subsidies. This made up 72% of their combined total revenue of over $3 billion (Tax Justice Network, 2018).

- Home care providers can charge high management and administration fees thereby reducing what participants can spend on actual care. These providers can set their own prices, service levels and schedules with recent analysis showing that providers spend about $1 billion a year on administration costs. This is about a quarter of the total allocated for a home care package, regardless of the level of service delivered. This is due to Australia's home care system being poorly regulated with no stewardship to develop, monitor, and manage home care providers on behalf of older people. (Daniel, 2021).

These examples highlight the need for more comprehensive financial standards and greater regular and timely reporting and transparency that holds private aged care providers publicly accountable to protect this vulnerable cohort. The same standards of care and reporting mechanisms operating in the acute sector must also apply in aged care. That profit-making is a driving factor in the aged care sector with no link to the quality of care, is unacceptable and fundamentally flawed.

The QNMU contends that the current dire situation in the provision of aged care, which has been clearly identified over several years, and most comprehensively in the final report of the Aged Care Royal Commission, has resulted in large part because of a market-based approach to an area of essential health service provision. It is the experience of the QNMU that the predominately privatised and marketised aged care sector has largely put funding and cost foremost at the expense of care, safety and quality. We believe the current arrangements have led to the many structural issues apparent in the private aged care sector including:

- almost universally inadequate staffing and skill mix to meet the care and safety needs of those accessing aged care services both community-based and in residential aged care facilities;
- providers operating without guidance and in some instances, the clinical knowledge, to match staffing levels to care needs;
- providers making staffing decisions driven by budgetary considerations, rather than ensuring delivery of safe, quality care;
- inadequate accountability or transparency of how government subsidies are spent;
- lack of primary care and clinical capacity to meet the often complex care needs of older Australians, where the numbers of RNs and ENs have significantly declined and have been replaced by a far less capable, though cheaper, unregulated care worker labour force;
- development of a compliant, low cost, tenuously employed workforce, often on minimum hours contracts that could well be described as the "working poor" of aged care.

The QNMU agrees that the public hospital system should be equipped to handle any increase in hospitalisations, and this includes presentations of patients from aged care facilities. However, it is apparent that many residential aged care providers default to sending their

residents to hospital when the care they need is something you would expect to receive from an RN or GP in an aged care facility. Research shows nearly 37% of Australian aged care residents over 65 were taken to an emergency department for treatment at least once during 2018–19 (Royal Commission into Aged Care Quality and Safety, 2021b). We know from our members that aged care residents are being sent to emergency departments for procedures such as a catheter change, intravenous fluids (IV), basic wound reviews and urinary tract infections which if there was the right skill mix and number of RNs employed at residential aged care facilities these could be addressed within the facility. With a mandated number of nurses on shift in all residential aged care facilities, we believe this could be prevented, therefore decreasing the impact on the health care system.

NDIS

Access to safe, effective and high-quality healthcare is a basic human right. This right recognises that every person has the right to the highest attainable standard of health without discrimination on the basis of disability (Convention on the Rights of Persons with Disabilities, 2008). Unfortunately, the recent Disability Royal Commission has heard from those with a disability and their advocates, with many reporting insufficient care and access to health care and services. That both the Aged Care and Disability Royal Commissions have had similar issues presented is profoundly distressing with reform in these health care sectors glaringly overdue.

Much like the aged care sector, we believe there is potential for increased collaboration and integration between disability and health care, such as community health services and Primary Health Networks (PHNs). In our view this will lower the impact on Queensland's public health system as the right care at the right time will be delivered and not be transferred to the hospital system. Nurses are critical to this work. Nurses have the skills, expertise, and qualifications to perform roles that support NDIS participant empowerment and self-sufficiency. The NDIS must enable nurses to work to their full scope of practice and recognise the specialised and vital role of nurses in the assessment, education, and capacity building of participants with complex disability needs.

The QNMU also asks the Committee to consider the prevalence of clients with intellectual disability being detained in mental health units because of challenging behaviours. This situation is offensive to those suffering a disability without any comorbid mental illness and serves to perpetuate the community stigma associated with both mental illness and intellectual disability. It also occupies valuable mental health clinical and administrative services, as well as occupying beds and thereby reducing the availability of acute mental health beds for those that really need them. As an example, the QNMU presents the following case study:

Case study 1 – Mental health unit

A young man with a severe disability was admitted to a mental health unit for over 12 months despite no mental health diagnosis or history, due to his complex challenging behaviours related to his disability. The treating team concluded that he required 24/7 care from experienced clinicians with a specialist qualification in his area of disability. While he has an NDIS package, it was insufficient to cover the cost of providing specialist home support services for the management of his behaviours.

QNMU members have also raised concerns regarding delays in discharging patients to NDIS-funded accommodation, citing the scarcity of facilities who employ a specialised clinical workforce capable of meeting the complex support needs of patients with specific disabilities. As an example, the QNMU presents the following case study:

Case study 2 – Medical unit

A young woman receiving NDIS support was admitted to an acute care medical ward, where she was successfully treated for a medical issue. However, the lack of appropriate post-discharge accommodation options suitable for her disability needs resulted in an inappropriately long length of stay on the ward, effectively "trapping" her in the acute care sector. The experience on an acute ward led to significant distress and agitation for the patient. Additional nursing staff were required to be rostered on to manage the increased acuity of the patient and disruption to the ward as a result.

The QNMU believes there is an urgent need for a specialist clinical workforce with the skills, training, and education to manage specific types of disability. The absence of such a workforce may be a contributing factor to the supply gaps for supports and services for NDIS participants particularly those with complex needs which may be contributing to people with disability remaining in hospital for longer than is medically necessary. The Queensland Government (2020a), in their submission to the *Inquiry into the NDIS Market in Queensland*, stated that (**bold** emphasis added): "The quality of providers in the market is not able to meet the complex needs of many patients being discharged from hospital. They **often do not have a sufficiently skilled workforce** to accept referrals immediately or to sustain the levels of care that are required within the community." This is extremely problematic as NDIS participants may become inappropriately held in the acute hospital sector due to a lack of disability support options post-discharge, placing a strain on the patient and the health care system. As an example, the QNMU presents the following case study:

Case study 3 – Rehabilitation unit

A random workload monitoring audit by the QNMU of a single day in a specialised rehabilitation unit in a tertiary hospital revealed that on that day, there were at least 15 patients who were experiencing delayed discharges from hospital due to the lack of appropriate NDIS community-based services. Sourcing adequate in-house clinical care was challenging for the level of disability support and assistance required.

In our view, the Queensland government has a role to play in ensuring the NDIS is working to the benefit of its recipients by:

- taking a proactive and central role in workforce planning, specifically in facilitating and driving the training and development of a qualified and work-ready workforce;
- planning of this workforce should be at both the commonwealth and state and territory level to account for localised issues in Queensland such as the large disparity of service access across regionality (Joint Standing Committee on the National Disability Insurance Scheme, 2020);
- ensuring NDIS funding is inclusive of RNs as they are an important part of the NDIS workforce where they can provide supervision to unregulated carers where nursing tasks are being performed with NDIS participants to minimise risk and improve outcomes;
- investing in robust research into the impact of job quality on service quality in the NDIS. The QNMU welcomes the establishment of the National Disability Research Partnership (NDIS, 2020a) and anticipates further insight into the impact of job quality of disability workers on the quality of service provided;
- funding and financial incentives that take a targeted approach to the provision of disability care to accurately reflect the regionality-based needs of the state;
- working with the *National Disability Strategy 2021-2031* (Commonwealth of Australia, 2021) in ensuring the rollout of the strategy delivers the outcome areas for those with disability and those seeking supports and services like the NDIS.

Rapid growth in technology is changing traditional models of healthcare with digital platforms shifting how healthcare is delivered. Technology has evolved to enable the 'uberisation' of work in disability and aged care. The development of digital platforms has coincided with the change and growth in the disability sector where once consumers received support from generally one organization to a now more fragmented approach to support programs. Data shows that since the introduction of the NDIS in March 2013, there has been continual growth in participant numbers with almost 400,000 people with disability being supported by the NDIS. The active providers have also grown by almost four times since 2017 from 4,005 to 14,882 in June 2020 (NDIS, 2020b). This NDIS delivery model has propelled the rapid emergence of gig-type arrangements. These digital platform brokers operate under a

business model. They are not service providers, they are not covered by labour hire licensing regulation, they do not provide oversight or supervision of care workers and they have no responsibilities for employment or care (Baines, MacDonald, Standford and Moore, 2019).

To that end, the QNMU unequivocally supports a safe and competent NDIS workforce through the registration of NDIS providers. The regulatory requirements for these providers will ensure a skilled and safe workforce of AINs, ENs and RNs who have relevant qualifications and/or licenses.

As a publicly funded institution that supports some of the most vulnerable people within our community, the NDIS must be open to public scrutiny and regulatory oversight and administration. The QNMU is concerned that self-regulation of the market has clearly failed in the case of the aged care sector; it appears that the disability sector may be falling prey to some of the same predatory business models and practices that take advantage of a complex, confusing NDIS system to financially exploit participants. As it currently stands, the NDIS is provider-driven and not participant-driven. This approach must change. Support provision must be responsive to the needs of the person accessing it and acknowledge that the participant is the expert on their needs. This value-based approach aligns disability health care service delivery with patient-centred care.

1.c. The provision of the private health care system and any impacts the availability and accessibility of these services have on the Queensland public health system

Queensland's health care system is a blend of private and public services which are delivered by a range of health practitioners in a variety of settings. The COVID-19 pandemic has seen the public and private health care sectors in Queensland working together to meet the health care needs of the state and respond to COVID-19. This was evident in the early stages of the pandemic where the National Cabinet temporarily suspended all non-urgent elective surgery in both the public and private hospital systems to ensure the healthcare system could cope with an influx of potential patients and to preserve stocks of personal protective equipment (PPE). It was during this time the Queensland Government signed a *National Partnership Agreement* with the federal government ensuring private hospitals remain financially viable over the COVID-19 pandemic, in return for agreeing to provide their facilities, staff and supplies to support the COVID-19 response. Twenty-eight private hospital operators signed the agreement with the Queensland Department of Health, illustrating how the public and private sectors can work together for the health of the state (Queensland Audit Office, 2021a).

The private health care system plays a significant complementary role in Australia's provision of health care. Over 40% of Australians have private health insurance, encouraging patients to access the private health sector (Duckett & Moran, 2021). This is reasonable given private patients generally have shorter waiting time for treatments, the ability to choose their health

practitioners and enjoy better amenities such as a private hospital room (Rana, Alam & Gow, 2020). The belief that there are longer waiting times in the public health system is a determinant of a patient taking out private health insurance and using the private health care system. So too are the tax incentives provided to individuals who hold appropriate levels of private hospital health insurance coverage. And yet, some patients continue to use the public health care system regardless of having private health insurance. This may indicate a lack of coherence in the insurance policy, excessive medical fees not covered by insurance arrangements, or a perceived higher quality and specialisation of public hospitals compared to private hospitals. Proximity may be another reason for choosing public health services (Rana, Alam & Gow, 2020).

With private health insurance premiums continuing to rise, out-of-pocket costs increasing and dissatisfied consumers dropping their private health insurance cover, this raises many questions as to the sustainability of the private health care sector and private health insurance, with calls for the federal government to clarify the purposes of private health insurance (Duckett & Nemet, 2019). Questions such as does private health care save costs overall? Is it to reduce the total spending on health even if government spending were higher because there were more public and fewer private health care services? If private hospitals are more efficient overall than public hospitals, then encouraging people to use private hospitals would contribute to the overall efficiency of the health system?

We recognize there are differences between public and private health services which can make it difficult to compare the efficiency of these health systems, such as:

- case-mix and treatment complexity;
- workforce;
- differing standards and regulations;
- reporting and accountability.

A joint interest in the sustainability of the private and public health care systems is imperative for both systems to continue. Ensuring the provision of health care is available and accessible is dependent on both the private health care sector and the public health care sector. Key stakeholders of both industries must be engaged with the goal of creating sustainability of these health care sectors.

To that end, the QNMU seeks the state and federal governments to commit to keeping our health system in public hands, not privatising services or beds. We submit that the level of care and service provision and access is at risk when profit is a central driver.

2.a. In conducting this inquiry, the Committee should consider the current state of those services (outlined in 1) in Queensland

The COVID-19 pandemic has exposed issues in public health systems world-wide, and Queensland is no different. In our view, it is time for the swift and serious re-evaluation of how Queensland's public hospitals and health services are funded, designed, staffed and operated. This must occur now to ensure demand surges are met safely and government funding is best spent. The lack of proper public health service planning has created short-term crisis management that adversely impacts the public system and puts patients at risk and causes invaluable frontline health workers to experience extreme stress and burn out. This situation is now untenable and unsustainable for both patients and health workers. Identified solutions include better health system design, enhanced connection between services, the improved management and prioritisation of health services and new fit for purpose federal and state government health care funding frameworks. We believe the planning and management of the surge in COVID-19 patients needs a co-ordinated response to deal with this crisis and the subsequent pressure on the Queensland public health system.

As part of this inquiry, the QNMU believes the Committee must consider the variability that exists across Queensland Health due to the devolved governance arrangements that currently exist. Although we support the ability of HHSs to be responsive to the needs of their particular communities, this should be done in the context of ensuring transparency and consistency of approach with respect to the implementation of government policy priorities and ensuring compliance with legislative and industrial requirements.

We respectfully acknowledge the work being undertaken by the Queensland government in the implementation of the recommendations from the 2019 review into Queensland Health's governance framework (McGowan, Philip & Tiernan, 2019). We are hopeful this work will see a decrease in variability across the HHSs and eagerly await to see the outcomes.

2.b. In conducting this inquiry, the Committee should consider bulk billing policies, including the Commonwealth Government's Medicare rebate freeze

The QNMU believes the current health funding model is fragmented and needs an urgent review as it does little to support integrated care and focuses funding predominately on activity and not outcomes. In addressing this term of reference, we will briefly look at the Medicare rebate freeze, bulk billing, funding restraints and how to achieve a financially sustainable health care system. We again reiterate our *Health Needs Urgent Care* (2021a) campaign where we are urging federal and state governments to:

- invest in the health system by committing to working with health workers on a joint, immediate solution;
- work with health workers to identify long term solutions for a sustainable health system and economy;
- commit to smarter funding that is in the best interests of patient care and staff safety;

- commit to keeping our health system in public hands, not privatising services or beds.

As part of the campaign, we have outlined that in order to achieve a financially sustainable health care system, the QNMU supports:

- the introduction of a permanent shared 50-50 commonwealth-state funding model for public hospitals and remove the 6.5% per annum cap on the efficient growth of activity based services for 2022-2023 to 2024-2025 financial years;
- the establishment of an innovation fund to trial and evaluate new models of funding which would complement the current ABF model in order to:
    - address demand;
    - improve performance, capacity and innovation;
    - support integrated care; and
    - provide greater access to health resources and better weighted funding models to First Nations people and other disadvantaged groups to improve non-medical and medical conditions which influence health outcomes.
- the establishment of a transition fund to move to new funding arrangements after successful evaluation of such trials;
- evaluation being Incorporated as a standard component of all new funding arrangements in order to provide assurance of both quality health outcomes and efficiency in the health system;
- clinically integrated acute, primary, disability and aged care health systems to improve physical, mental and social health and wellbeing;
- removal of fee-for-service arrangements for GPs which drive increases in costs and move to a per capitation model which drives innovation, efficiency and better health outcomes.; and
- investment in community education to shift patients away from hospital and into care in the community.

The QNMU takes this opportunity to discuss 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 MBS. In many instances' nurses are limited in the MBS items they can utilise (Australian College of Nursing, 2020). To overcome these funding barriers, we suggest:

- 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 made 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);
- developing funding mechanisms that support teams of nurses; and
- uncoupling Work Incentive Program (WIP) block funding of nurses in general practice from being tied to GP numbers (Australian College of Nursing, 2020).

Ensuring nurses and midwives can work to their full scope of practice improves patient outcomes, enhances productivity and is better value for money for health services (Australian College of Nursing, 2020).

The QNMU is also concerned with short funding cycles of community-based organisations and services. We have previously addressed this issue in our recent submission to the Community Support and Services Committee for the inquiry into social isolation and loneliness in Queensland. Short funding cycles, at times contracting services for only one year, results in organisations facing deep uncertainty over the sustainability of their service. This is compounded by short notice periods regarding whether funding will be renewed, at times only weeks prior to the contracted term. Insecure funding causes disruption, anxiety, and distress among participants and staff. This can further impact on the following issues:

- *Job insecurity and workforce issues*:
    - Short funding cycles result in limited ability for community organisations to offer staff anything other than temporary or casual contracts, leading to increased job insecurity in the sector. The limited prospects of permanent positions in community services may act as a deterrent for qualified staff to apply for such positions, resulting in difficulties in recruiting and retaining staff. For an industry that relies heavily on fostering and developing relationships with participants, a 'rotating roster' of staff can have a detrimental impact on the ability to support the community (Blaxland & Cortis, 2021).
- *Limitations on long-term planning:*
    - Uncertainty over funding can also impact on an organisation's ability to form or sustain long-term relationships with the community (Blaxland & Cortis, 2021). Moreover, predictability of funding is necessary for organisations to plan long-term community goals and programs and to enable ongoing change within communities.
- *Poorer outcomes for participants*:
    - Short funding cycles can impact the ability for people who access community programs and services to forge meaningful relationships with others in the

community. For some, community programs such as neighbourhood centres may be their only opportunity for social interaction with peers. With many programs focusing on independent living skills and social connection, disruption or uncertainty regarding such programs can lead to significant distress, especially among demographics that already face stigma and ostracization.

As an example, the QNMU presents the following case study:

Case study 4 – Children's Health

The right@home program (Children's Health HHS) and the Home Visiting program (Gold Coast HHS) were earlier this year informed by the Department of Children, Youth Justice and Multicultural that their funding was to be cut after the program had been successfully running for over 10 years. These programs see child health nurses deliver crucial support to hundreds of vulnerable new and expecting families and have been shown to improve parental bonding, maternal mental health and children's literacy. After lobbying from the community, nurses, other health care staff and the QNMU, funding was reinstated for one more year ensuring vulnerable families receive the support they need.

The QNMU recommends the government reviews the current funding and contracting arrangements with community organisations to promote and enable longer and secure funding cycles and flexible contracting terms.

In addition, we would support the review of the Medicare rebate freeze as it is having a flow-on effect on the rest of the healthcare system. We are seeing non-urgent patients presenting to emergency departments as they are either not wanting to pay out-of-pocket costs to see a GP who charges higher than the Medicare rebate or cannot get into a bulk-billed medical centre in a convenient timeframe.

2.c. In conducting this inquiry, the Committee should consider the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas

The QNMU has no comment.

2d. In conducting this inquiry, the Committee should consider the availability of medical training places at Queensland universities, compared to other jurisdictions

The QNMU suggests the Committee not only considers the availability of medical training places at Queensland universities but also places for other health practitioners, including nurses and midwives.

As of the end of March 2021, Queensland had:

- almost 69,000 RNs and almost over 15,500 ENs;
- approximately 6,000 midwives registered (Nursing and Midwifery Board of Australia, 2021);
- just over 26,000 medical practitioners registered (Medical Board of Australia, 2021);
- almost 7,500 physiotherapists registered (Physiotherapy Board of Australia, 2021); and
- over 5,100 occupational therapists registered (Occupational Therapy Board of Australia).

Given the large number of health practitioners other than medical doctors who are registered to work in Queensland, we believe the availability of training places at Queensland universities should be extended to be inclusive of all health practitioners to assist in addressing future skills shortages in the health sector. Any increase in graduate numbers must then be supported with increased clinical educators and graduate program places to support the transition.

We also draw comparison to the differences in graduate programs between medical practitioners and nurses and midwives. The transition from student to RN or midwife involves many changes in roles and responsibilities. And yet, nurses and midwives are not required to undertake transition programs, nor are there coordinated, formalised graduate programs, unlike their medical colleagues. The QNMU believes that new graduates need support and a period of structured transition when first employed as a nurse or midwife, in order to progressively develop their clinical skills and confidence.

We also note federal Labor's recent announcement that if they win the next federal election, they will provide free TAFE places in nominated areas of skills shortage that includes aged care, disability care, nursing and community services. It is proposed that this will be a shared funding arrangement between a future Labor government with states and territories. The aim of the package is to meet current and future needs in the health and care environment. Given the National Disability Insurance Agency (NDIA) forecasts a substantial increase of employment in the disability sector and the NDIS and one of the recommendations from the Aged Care Royal Commission was the aged care workforce and their training, the QNMU is supportive of these measures (McKell Institute, 2021).

As stated in our introduction the QNMU will now address a number of key elements of Queensland's health care system: workforce planning, ambulance ramping, the demand on emergency departments, mental health and palliative care.

Workforce planning

To sustainably manage Queensland's health care system, the QNMU supports a strong preventative approach to health care, with all health disciplines using their full skill sets. As part of this approach are nurses and midwives working to their full scope of practice where they are able to improve the health of the community through preventive health and chronic and complex disease management which keep people well and out of hospital (Booth, 2019).

Nationally, policy concern about the increasing demand for health care coupled with an inadequate workforce to meet projected needs resulted in the establishment of Health Workforce Australia (HWA). The federal government established HWA to deliver a national, coordinated approach to workforce reform with an overall goal of building a sustainable health workforce for Australia (HWA 2013a cited in Buchan, Twigg et al., 2015). While HWA was able to gather national data and develop policy levers for managing the health workforce, in 2015, the federal coalition government closed it down. Thus, although its projections and responses may have been different over time, its focus on the health workforce was a welcome insight into an area of growing concern in an ageing population. The HWA predicted that population health trends, combined with an ageing nursing workforce and poor retention rates, will lead to an imminent and acute nursing shortfall of 85,000 nurses by 2025 and 123,00 nurses by 2030.

Increasing workloads, understaffed shifts, double shifts and regular overtime are becoming normalised and are leading to staff burning out. Workforce planning is desperately needed to support exhausted nurses and midwives and other health practitioners. For many, their existing workload has been on top of the COVID-19 response which has involved testing, tracing, screening, isolating, vaccinating and treating the disease. These workload problems aren't new, but they have been exposed and exacerbated by the COVID-19 pandemic.

We urge the state government to focus on five priority areas that would make a difference right now to staff and patients:

1. *Address current excessive demands on the workforce*:
    a. Prioritise the prompt resolution of workload concerns.
    b. Focus on safety first – make keeping health workers physically, psychologically and culturally safe a system priority.
    c. Place a limit on excessive overtime and implement strategies to enable staff to take leave.
    d. Promote job security through permanent employment within Queensland Health by prioritising the implementation of existing government policy.
    e. Prioritise effective, co-ordinated and responsive workforce planning at the central and local levels, including introducing strategies to maximize the existing workforce including increasing hours for any staff member seeking more hours and flexible working options.

2. *Review the demand drivers*:
    a. Urgently review and amend the drivers of current demand, including the funding model, so that innovative value-adding models of care that will better manage demand are prioritised and funded accordingly.
3. *Planning and accountability for delivery*:
    a. Establish clear system priorities through effective and inclusive planning and robust accountability mechanisms for the delivery of objectives across the health system.
4. *Devolve necessary authority*:
    a. Immediately implement strategies to ensure all health workers can work to their full scope of practice in order to support the growth of new models of care. This must also be linked to ensuring the necessary budgetary and other authority exists to drive the necessary system reform and enhance the delivery of responsive quality care.
5. *Moratorium on business cases for change*:
    a. Halt current business cases for change processes related to significant organisational change and restructuring and undertake a fundamental re-thinking of the purpose of the negative consequences of focusing on short term efficiencies rather than long term whole of health system sustainability.

In Queensland, there is a fear that the anticipated COVID-19 surge (which we are already seeing) will have enormous impacts on this already understaffed and under resourced workforce and their ability to provide quality care. Queensland Health workers are calling for a coordinated response to the planning and management of the impending surge in COVID-19 cases and associated expected increase in pressure on Queensland's public health system. While we understand the need to respond quickly to a crisis, there have been significant issues with personal protective equipment (PPE), staff vaccination rollouts and access to resources. These issues have only been resolved because of the involvement and engagement of workers via their unions. We urge the state government to meet with unions about the planning and management of the impending surge of COVID-19 cases and subsequent pressure on the health care system.

While the pandemic has brought to light the contribution and value of the nursing and midwifery workforces, it has also shown the health, wellbeing and safety of these workers must be protected. Strategies that include psychological support, investment in training and education, and recruitment and retention approaches are imperative. We must learn from the experiences of the nurses and midwives in New South Wales and Victoria as well as internationally, and the trauma they have experienced during the pandemic and the potential impact this will have on nurses burning out and potentially leaving the profession.

The International Council of Nurses (ICN) (2020) suggests one way to fill the impending nurse shortage gap is to increase the number of nursing and midwifery students. We acknowledge

this as one solution and add, however, that this does not address the problem of the three year gap before new graduate nurses are ready to enter the workforce, during which time experienced nurses may leave the profession. This shortage of experienced nurses and underemployment of graduate nurses sits alongside the ever-increasing demand for health care with shifts in the burden of disease and an ageing population.

In addressing the need for workforce planning, the QNMU sees several steps the state government can take:

- conduct research on the future health needs and patient preferences, based on current health and disease trends, demographics, population growth and ageing to determine where health care needs will be and the scope of practice of the health practitioners required to meet those needs. The Queensland government already has data showing that Queensland's population is ageing, and that it is anticipated that this will not be experienced in a uniform manner across the state, with HHS regions such as the Metro-North, Metro-South, Gold and Sunshine Coasts expecting to be greatly impacted by an ageing population while Torres and Cape and Central Queensland are less likely to see this growth (Queensland Government, 2019a);
- support growth of innovative nursing and midwifery models of care and other health practitioners that will enhance the ongoing sustainability and safety of our public health system. For example, the state government recently announced that GPs will be based at 50 schools throughout Queensland as part of a pilot program and the government's student wellbeing program. Given there are already school nurses in Queensland schools, we assert that school nurses already provide mental health services and support to school-aged children within the school environment. We would support expanding this initiative to include nurses;
- address nursing and midwifery workforce shortages through the development of a comprehensive workforce plan for Queensland, with a particular emphasis on the provision of scholarships and other support mechanisms;
- once the workforce needs are determined, assist in developing nationally consistent vocational education and training (VET) tertiary courses that will meet health care needs, in partnership with education providers, so that student intake and completion rates can be commensurate with anticipated need;
- provide incentives and supports and targeted recruitment for health workers to practice/work in regional, rural, and remote areas and continue to monitor the effectiveness of these strategies for a longer-term rural health workforce. This must include an emphasis on growing local health workforces in community, including a particular focus on increasing the growth of local First Nations nurses and midwives[2]. The QNMU asks that in the planning for health care in rural and remote areas,

[2] We note and welcome the federal government's recent announcement of a new incentive scheme that will remove the university debts for doctors and nurse practitioners who work in rural, regional, and remote areas. This incentive is aimed at attracting more health practitioners to these areas.

adequate, safe and timely accommodation for those who work in health care services be included. We recognise the wider economic and social impact that accommodation has in rural and remote areas as accommodation plays a major role in the attraction and retention of the health care workforce in rural and remote areas. Addressing the barriers to health practitioners working in a rural and remote area must be a priority, to ensure that the population living in rural and remote areas have equity of access to healthcare;

- growing the workforce in non-acute health settings including mental health, midwifery and aged care to shift health care out of acute hospitals;
- lobby the federal government to ensure private sector minimum wages and conditions are adequate and appropriate in order to attract and retain nurses and midwives.

The QNMU also wishes to draw to the Committee's attention the increasing risk our members face in being assaulted while at work. We know that acts of aggression towards individual staff members in HHSs has been rising. In the 2015/16 financial year there 3,719 serious assaults reported which has jumped to 6,321 in the financial year 2018/19 (Queensland Government, 2019c). No level of violence is tolerable in any workplace and for our members this means that there must be no violence in their workplaces which are our hospitals and health services. Increasingly, health and aged care services are being delivered in the community including in people's homes, so strategies must be developed to ensure the safety of workers in all these settings.

Ambulance ramping

Ambulance ramping occurs when hospitals are at capacity and is a symptom of a health system under stress. Direct action to address the root cause of the problem is needed and not merely to treat the symptoms. Patients waiting in ambulances on the hospital ramp to receive treatment is a major problem for Queensland's health care system. While making more beds available and boosting primary health care are some approaches there are other models too. One approach being successfully used in addressing the needs of people with mental health concerns is an early intervention model of care where RNs deliver mental health treatment and care in Ipswich, Queensland. The *Co-responder Mental Health Program* sees RNs picked up from the Ipswich hospital by a police car responding to an emergency call relating to mental health and attends the incident with the police service (Clinical Excellence Queensland, 2019). This program has reduced ambulance ramping and hospital patient numbers as these people are seen by the nurses and treated at home avoiding the need for assessment in emergency departments (Murray, 2018).

Demand on emergency departments

Patient demand for health care services in Queensland has been brought to light by the COVID-19 pandemic. And yet, Queensland's emergency departments and hospitals were

already experiencing heightened demand even before the virus hit Australia. This is due to insufficient hospital beds and/or staff to cope with the workload. There is also a lack of alternative community-based health services, for people to go to so they present to emergency departments. It is our great fear that demand will only increase with Queensland's projected population boom from interstate migration in the foreseeable future.

The volume of emergency department presentations in Queensland public hospitals is growing at a faster rate than population growth and more people are presenting at emergency departments with complex issues. 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, 2021c). The reasons for this increase in presentations is complex and varied. We need better data to inform enhanced planning and response.

The recent auditor-general's report (2021c) stated that controls over Queensland emergency department data must be improved so the data is complete, accurate and validated in a timely manner, making several recommendations to achieve this:

1. Data reliability
    a. Improving the accuracy of data recorded.
    b. Improving how patient off stretcher time is recorded and reported.
2. Performance measures
    a. Initiatives to promote measures of performance and outcomes in all parts of care.
    b. Develop and implement guidelines to identify measure so success.
3. Short term treatment areas
    a. Monitor and report on the use of short-term treatment areas such as short stay units.

The QNMU supports Queensland Health in working with HHSs to implement these recommendations to assist with the increased demand in emergency departments. We also acknowledge the hundreds of beds being occupied by aged care and disability care patients in Queensland's public hospitals and support the state government in continuing to lobby the federal government for alternative care arrangements for these patients.

Prior to the last Queensland election, the QNMU successfully lobbied for the establishment of a project to examine nursing workloads and models of care in emergency departments, and we look forward to this project officer starting in the New Year.

Mental health care

Investigating the provision of Queensland's health care system must include the increasing need for mental health care and the link between mental health and physical health and how this impacts overall wellbeing. Statistics show that in Queensland 23% of adults self-reported

a long-term mental or behavioural problem in 2017-2018 and mental health-related presentations to public emergency departments was 4.1% in 2019-20 and has been steadily rising over a number of years (Queensland Government, 2020b & Australian Institute of Health and Welfare, 2021). These figures show the large number of people who experience a mental health condition as well as needing mental health care and highlight the urgent need to undertake structural reforms in the service delivery of mental health care and funding arrangements.

We note the complexity of the current mental health system. Services are delivered by public and private systems and policies are developed by state and federal governments. Regulating and funding is also shared between the Australian and state and territory governments. This disjointed system inevitably leads to unclear responsibility and accountability and poor service provision and continuity of care. The QNMU's position continues to support the need for governments to give a commitment to mental health programs and services to ensure certainty of funding for the continuity of mental health services.

We believe nurses have a pivotal role to play in this health care service. The QNMU continues to seek the reinstatement of the Nursing and Midwifery Board of Australia (NMBA) endorsement for nurses with mental health qualifications to recognise mental health as a specialty area of practice, as do other National Boards such as the Psychology and Medical Boards. ENs, AINs and personal care workers (however so named) also play an important role in the mental health workforce. Given their essential role, ENs should be afforded the opportunity to complete additional training in mental health and suicide prevention, whether that be in the tertiary education sector or the vocational education and training (VET) sector.

The QNMU continues to advocate for specific funding that addresses the need for mental health nurses and the models of care they provide. Previous programmes and services such as the commonwealth funded *Mental Health Nurse Incentive Program* (MHNIP) was a collaborative program that supported mental health care nurses in Primary Health Networks (PHNs). Unfortunately, the responsibility of this funding has since been given to the PHN flexible funding pool. This has meant that mental health services are now commissioned to local providers by the PHNs to provide mental health care services which may not necessarily be provided by mental health nurses or other health practitioners with mental health training or qualifications. This has resulted in significant changes as to how mental health nursing services are delivered across PHNs.

Queensland's Mental Health Commissioner has recently put forward that counsellors and mental health nurses should qualify for MBS funding to assist with the major workforce shortages that are seeing people waiting between three and 12 months for an appointment with a psychologist or psychiatrist. The QNMU has long campaigned for increased access to mental health care and expanding who can provide mental health care. We believe mental

health nurses should be involved in every step of the *Stepped care model in primary mental health care clinical service delivery* (Australian Government, 2019). Currently, workforce requirements in the model only have mental health nurses working in the highest end of the spectrum which is dealing with patients with severe mental illness. We would suggest PHNs could make better use of the mental health nursing workforce and use this workforce at all stages of the stepped care model. Mental health nurses have the skills, qualifications and experience to work across the whole spectrum of care including those patients with episodic mental ill health and those with high needs (Australian College of Mental Health Nurses, 2018).

To inform the future approach to mental health care, we believe there is the need for data collection that includes the number of patients in mental health crisis who present to a hospital emergency department:

- with a mental illness or disorder and who are being refused admission;
- the reason for not admitting the person is due to the shortage of beds, or their condition is not severe enough, or hospital/medical policy;
- what are the consequences for people with mental health concerns who are not admitted, or are not being seen in the emergency department in a timely manner?
- or leaving due to lengthy delays in assessment;
- if covered by private health insurance, referred to a private mental health unit. If the cost of treating mental illness is being shifted to the private sector, is this resulting in additional costs for health insurance companies and subsequent increases in premiums?

We suggest one solution in providing additional mental health care is the funding for more community-based extended-hours services. This would provide an alternative for people with a mental illness or disorder or suicide ideation having to present to hospital emergency departments, thereby avoiding hospital admissions and freeing up hospital beds. The QNMU acknowledges that boosting the number of community-based mental health facilities is just one part of the mental health system and sits alongside other measures that shift expenditure from acute, hospital-based and late-intervention health services to prevention focused, early intervention and recovery.

We also support further investment in crucial mental health support for adolescents. Recent data shows that there has been a 12% increase in mental health triple-0 calls to the Queensland Ambulance Service in three years, with 52,000 in 2019 and 59,000 in 2020, with an alarming rise in call-outs for children (Chamberlin, 2021). We believe both the state and federal governments have a responsibility to make sure that mental health care is provided for all age groups. We acknowledge that there is no 'one-size-fits-all' approach for adolescents and that care often falls between child and adult mental health services. Yet, this must not prevent an ongoing strategy for mental health support and services for adolescents.

Palliative care

We believe that a review that addresses access and funding of palliative care services should be included in this inquiry. As part of the palliative care strategy must be the commitment to ensuring palliative care services are delivered in a range of settings with equitable access to high quality palliative care, not only in the south-east corner of Queensland but extending to regional, rural, and remote areas of the state. Palliative care must also have adequate resourcing with suitably qualified and adequate numbers of nurses for those requesting and/or requiring palliation.

In addition, when the voluntary assisted dying scheme begins in Queensland this must not divert resources and/or funding from palliative care.

We recognize the state government's ongoing investment in Queensland's palliative care system and the work of the *Palliative Care Reform Package*. We are supportive of the government's focus on growing and investing in a specialist palliative care workforce and developing a workforce plan that is inclusive of the important role of nurses.

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