THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to

The Independent Hospital Pricing Authority

Pricing Framework 2017-2018

October, 2016

Queensland Nurses' Union
106 Victora St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
P (07) 3840 1444
F (07) 3844 9387
E qnu@qnu.org.au
www.qnu.org.au

Introduction

The Queensland Nurses' Union (QNU) thanks the Independent Hospital Pricing Authority (IHPA) for providing the opportunity to comment on the *Consultation Paper on the Pricing Framework 2017-18* (the paper).

The QNU is the principal health union in Queensland. Nurses and midwives are the largest occupational group in Queensland Health and one of the largest across the state of Queensland. The QNU covers all categories of workers that make up the nursing and midwifery workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our nearly 54,000 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 QNU.

Our submission responds to a subset of the consultation questions.

Do you support IHPA's intention to introduce a bundled price for maternity care in future years?

The QNU has recommended in previous submissions that IHPA align bundled pricing to evidenced-based models of care to direct and reinforce the implementation of best practice in public health services. We strongly support the consultation that IHPA has undertaken over the last 12 months around maternity care.

Midwifery continuity of care models provide optimal outcomes for women and their babies which has been demonstrated in large bodies of current research [1]. The focus on cost and outcomes in maternity care in the recent Lancet series on Maternal Health demonstrates that Australia's increasing levels of medicalisation in birth are not improving outcomes and are most certainly negatively impacting the health budget [2] [3]. Midwifery models of care, and potentially other evidence based innovations in maternity care, could be well supported by the introduction of bundled payments.

The QNU supports the introduction of bundled price for maternity care, potentially in 2018, as set out in the paper. Current research has concluded that most women should be offered midwifery continuity models of care and therefore we are supportive of models of funding which will assist to drive reform in this area. A focus on consumer outcomes and minimum datasets as per national and international standards is highly recommended when bundled

payments are adopted to support the continual improvement and delivery of safe, high quality healthcare.

What stages of maternity care and patient groups should be included in the bundled price?

All stages of maternity should be included. Antenatal and postnatal care are easily defined and could be bundled separately i.e. a bundle for antenatal care and a bundle for postnatal care. This will allow for greatest flexibility in costing and funding. Intrapartum care should be defined as per the current AR-DRG's, for example, vaginal or caesarean delivery of minor, intermediate or major complexity but could represent or include specific elements of admitted care. An alternative is that intrapartum care could be bundled with postnatal care according to the complexity of the AR-DRG for intrapartum care as it could be expected that there would be an increased requirement for postnatal care for those who experience complicated births.

As outlined in the discussion paper the potential included/excluded patient groups need more extensive consideration. The inclusion of most women is possible by bundling uncomplicated care and vaginal birth. There may be a need to include some level of caveat as per the paper (i.e. primiparous and multiparous women would require a different number of visits included within the bundle). The exclusion of those experiencing antenatal and postnatal care outside the hospital setting such as those in shared care arrangements with GP's, and those experiencing private obstetric and private midwifery care may have a significant impact on the usability of this model of funding. There is a potential that these women could be included for the elements of care that are to be provided within the hospital sector i.e. they may have postnatal care from the hospital.

A bundled approach to funding maternity care across all sectors (Medicare, hospital funding, and private health funders) should be organised in such a way that it promotes continuity of care. This would assist in providing most efficient models of funding and data collection but would require extensive work which could be suggested by IHPA to government/s.

Should IHPA include postnatal care provided to the newborn in the bundled price?

There are challenges in the current funding model around the "unqualified" newborn. Methodologies to fund care of the newborn need to be considered urgently and certainly prior to 2018. Funding for inpatient postnatal care must include a separate allocation for the newborn or funding for the well woman must be increased to consider the volume of work generated by the newborn. The newborn is considered as a separate entity in Coroners' court [4] [5] and therefore it is important to ensure adequate provision for care. This will be discussed further below.

What other issues should IHPA consider in developing the bundled price?

Funding for care of the newborn infant is not included in ABF funding at this time. There are over 300,000 babies born in Australia each year [6]. Many tens of thousands of these babies are not recognised as patients. The "qualified baby" is defined under *Health Insurance Act 1973* regulations as a funded patient where:

- They occupy a bed of an accredited neonatal intensive care facility;
- They are a second or subsequent child of the same mother; or
- They are admitted without their mother [7].

Neonatal care for qualified babies includes care of newborns who are suffering from illness or disability and could include many aspects of monitoring, oxygen therapy, administration of IV drugs and post surgical care. Evidence indicates that the mother and baby dyad should remain together where possible [8]. Therefore many babies who were once cared for within the Special Care nursery are now cared for on the postnatal ward. Babies requiring care such as phototherapy, drug administration and monitoring on the postnatal ward create additional work for the midwifery staff, for which health services are not funded.

Women's Healthcare Australia provided a presentation to IHPA in 2015 demonstrating a survey of their membership. On the day of survey alone 1,193 babies were being cared for - 51% (n=614) were unqualified and remained with their mother, of these 34% were receiving no additional care but 66% (404 babies) were receiving some form of treatment including observations, low birth weight concerns, phototherapy, assisted feeding or other treatments such as drugs [6].

Currently the majority of hospitals' staffing models are based on the number of mothers who are inpatients as a result of application of the existing ABF funding models (i.e. only funding the care of the woman). This creates a disincentive to safe staffing. Recent policy changes around newborns have increased the amount of care a newborn requires even where that newborn is considered relatively low risk [7] [8] .

Bundled maternity care items could be used to provide an incentive for hospitals to practice evidence based care i.e. those utilising models of care demonstrated to be safe and provide better outcomes could receive additional funding. This will be considered in further detail below.

What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?

The QNU recognises a need to consider risk adjustment for safety and quality in pricing and funding models. Minimum nurse-to-patient ratios were legislated in Queensland in May 2016 and implementation began on 1 July. The impact of ratios on the NEP is as yet unclear, however follow-up research will give further insight into its effect on patient care. There is a

potential for increased staff requirements from implementation of ratios which will potentially impact the cost of service provision and therefore the NEP.

National and international studies provide evidence that the number, skill mix and practice environment of nurses and midwives directly impact the safety and quality of care provided within the health system. Minimum nurse-to-patient and midwife-to-patient ratios are an economically sound methodology which saves lives and improves patient outcomes. Health services with a higher percentage of Registered Nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and less adverse events such as failure to rescue, pressure injuries and infections [9] [10] [11] [12]. These studies indicate:

- Every one patient added to a nurse's workload is associated with a 7% increase in deaths after common surgery [9];
- Every 10% increase in bachelor-educated nurses is associated with a 7% lower mortality [9];
- Every one patient added to a nurse's workload increased a medically admitted child's odds of readmission within 15-30 days by 11% and a surgically admitted child's likelihood of readmission by 48% [10].

Hospitals with audited proof of ongoing safe staffing levels could be provided with funding incentives.

Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?

Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

The QNU has concerns regarding not funding sentinel events. There is a potential that not funding sentinel events may cause an undue bias against hospitals where these situations are more likely to occur. For example whilst maternal death is a tragic and at times preventable event, some hospitals are far more likely to experience this event than others (i.e. tertiary hospitals, particularly those specialising in women's services). Another example is that inpatient suicide again is more likely to occur in facilities where there is a mental health inpatient unit. There are some sentinel events which are most certainly related to human or system error – such as a procedure on the wrong limb or person causing permanent damage or death, discharge of an infant with the wrong parents. However sentinel events such as maternal death and inpatient suicide may occur despite the best efforts of the hospital team.

Reduction of funding – for any reason – will potentially have a negative impact on care provision as facilities try to deal with reduced budgets. If a facility is already experiencing one, or more, sentinel events, reduction of funding is not likely to improve outcomes.

What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?

The advantages of funding that combines incentives and penalties is that this approach provides an opportunity for hospitals to work harder to display positive attributes which may assist with elements such as data collection and system change. There is potential for penalties to add to system challenge and to potentially cause more negative outcomes as there may be restrictions in staffing and attempts to reduce budgets and restrict resourcing in order to maintain a reduction in funding. The opposite – funding incentives – is likely to actively enable improvements in care provision which then has the additional benefit of improvements in patient care and potentially outcomes.

Consideration of evidence based drivers to improve outcomes could include impact of staffing, rather than purely on funding, on prevention of poor outcomes and preventable readmissions. In Western Australia, increased nursing hours have resulted in 1088 life years gained based on prevention of 'failure to rescue' adverse events. The cost per life year gained was $8907, which is well below the reasonable cost-effective threshold in Australia of $30-60,000 per life year gained [13].

Further, a study of Victorian and Queensland public hospitals estimated hospital acquired complications such as pneumonia and urinary tract infections added 17.1% cost to a hospital admission [14]. Improved nurse staffing and skill mix levels will reduces these types of adverse events and minimise unnecessary costs [13] [9] [11].

Are there any other pricing or funding options that IHPA should consider in relation to HACs?

Significant change is under way in relation to nursing and midwifery within Queensland. As highlighted above in delivering on its promise to implement nurse-to-patient ratios, the Queensland government has taken action to improve patient safety and quality of care. We recognise the additional nursing and midwifery staff will involve extra cost and may therefore affect the NEP. In the longer term however, we can anticipate improved patient outcomes and reduction in costs associated with adverse events, readmissions, complications and mortality and are committed to demonstrating this through the establishment of an agreed evaluation framework.

Incentivising, with funding mechanisms, hospitals that provide data and demonstrate low levels of Hospital Acquired Conditions (HAC's)and other quality measures could significantly

impact and improve hospital outcomes, which will in turn, improve hospital efficiency and reduce costs.

References

[1] J. Sandall, H. Soltani, S. Gates, A. Shennan and D. Devane, "Midwife-led continuity models versus other models of care for childbearing women.," *Cochrane Database of Systematic Reviews,* vol. Art. No. CD004667. DOI:10.1002/14651858.CD004667.pub5, no. Issue 4, 2016.

[2] S. Miller, E. Abalos, M. Chamillard, A. Ciapponi, D. Colaci, D. Comande, V. Diaz, S. Geller, C. Hanson, A. Langer, V. Manuelli, K. Millar, I. Morhason-Bello, C. Pileggi Castro, N. Pileggi, N. Robinson, M. Skaer, J. Paulo Souza, J. Vogel and F. Althabe, "Beyond too little, too late and too much, too soon, a pathway towards evidence-based, respectful maternity care worldwide," The Lancet, 2016.

[3] D. Shaw, J. Guise, N. Shah, K. Gemzell-Danielsson, K. Joseph, B. Levy, F. Wong, S. Wood and E. Main, "Drivers of maternity care in high-income countries: can health systems support women-centred care? Maternal Health 4," The Lancet, 2016.

[4] Office of the State Coroner, "Inquest into the death of Arisa Huber," Queensland Coroners Courthttp://www.courts.qld.gov.au/__data/assets/pdf_file/0017/113642/Huber-Findings.pdf, Brisbane, 2007.

[5] Office of the State Coroner Queensland, "Inquest into the death of Bela Heidrich," Queensland Coroners Courthttp://www.courts.qld.gov.au/__data/assets/pdf_file/0007/95515/cif-heidrich-b-20110629.pdf, Rockhampton, 2011.

[6] Women's Healthcare Australiasia, "The changing costing picture for Australian maternity services: improvements and challenges ahead," in *IHP Activity Based Funding Conference 2015*, Adelaide, 2015.

[7] Queensland Health, *Gestational Diabetes Mellitus. Guideline No MN15.33-V1-R20,* Brisbane: Queensland Clinical Guidelines, 2015.

[8] Queensland Health, *Queensland Clinical Guildelines Neonatal Hypoglycaemia,* Brisbane: Queensland Clinical Guidelines, 2013.

[9] L. Aitken, D. Sloane, L. Bruynell, K. Van den Heede, P. Griffiths, R. Busse, M. Diomidous, J. Kinnunen, E. Kozka, E. Lesaffre, M. McHugh, M. Moreno-Casbas, R. A, R. Scwendimann, P. Scott, X. Tishelman, T. Acterberg and W. Sermeus, "Nurse staffing and education and hospital mortality in nine European countries:a retrospective observational study," *Lancet,* vol. 383, no. 9931, pp. 1824 -1830, 2014.

[10] H. Tubbs-Cooley, J. Cimiotti, J. Silber, D. Sloane and L. Aiken, "An observational study of nurse staffing ratios and hospital readmission among children admitted for common conditions," *BMJ Quality and Safety,* vol. 0, pp. 1-8, 2013.

[11] A. Lankshear, R. Sheldon and A. & Maynard, "Nurse staffing and healthcare outcomes:a systematic review of the international research evidence," *Advances in Nursing Science,* vol. 25, no. 2, pp. 163-174, 2005.

[12] M. McHugh, J. Berez and D. and Small, "Hospitals with higher nurse staffing had lower odds of readmission penalties that hospitals with lower staffing," *Health Affairs,* vol. 32, no. 10, pp. 1740 - 1747, 2013.

[13] D. Twigg, E. Geehoed, A. Bremner and C. & Duffield, "The economic benefits of increased levels of nursing care in the hospital setting," *Journal of Advanced Nursing,* vol. 69, no. 10, pp. 2253-2261, 2013.

[14] T. Jackson, H. Nghien, O. Rowell, C. Jorm and J. Wakefield, "Marginal costs of hospital-acquired conditions: information for priority-setting for patient safety programmes and research," *Journal of Health Services Research and Policy, ,* vol. 16, no. 3, pp. 141-146, 2011.