Queensland Nurses & Midwives' Union

Submission to Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2019-20

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Independent Hospital Pricing Authority (IHPA) for the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20*.

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 categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 58,000 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.

The QNMU has framed our responses to the consultation questions through the lens of the following concepts:

- value-based care as it represents a more consumer focused method of categorising/classifying healthcare to improve the quality of patient experiences and outcomes;
- models of nurse/midwife practice that allow nurses and midwives to practice to their full scope of practice; and
- access for all to adequate healthcare, regardless of where they live, and the choice to select the healthcare they wish to receive.

We acknowledge the work IHPA is doing in the development and refinement of the national activity based funding (ABF) system and the National Efficient Price and National Efficient Cost Determinations 2019-20 (NEP19 and NEC19).

The QNMU's submission responds to a subset of the consultation questions.

Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?

The QNMU supports the proposed timeframe of 1 July 2019 for the release of AR-DRG Version 6.X, provided the provision of quality health services by nurses and midwives is not compromised by this transition.

What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

The QNMU takes the opportunity to comment on the teaching, training and research that is part of this Section 4 – *Classifications used by IHPA to describe public hospital services* of the consultation paper.

We support the important role of teaching, training and research and the classification of these activities to ensure better management, measurement and funding. The classifying of midwifery and nursing as professions in the classification system for patient costing is advocated and commended.

Further, the QNMU suggests the use of the business planning framework (BPF) as a reference point for the actual teaching, training and research workload management needs of nursing and midwifery.

The BPF has been industrially mandated in Queensland as the primary methodology for managing nursing and midwifery workloads since 2003.

Should access to the public hospital data held by IHPA be widened? If so, who should have access?

The QNMU recommends IHPA widens access to public hospital data with these provisos:

- all data be deidentified;
- all data users and the reasons for their use of the data must be identified;
- private health insurers must not have access to this data for risk assessment; and
- there are strict penalties for misuse or negligence.

In a submission to Queensland Health in 2017 on expanding healthcare quality and patient safety reporting across Queensland's health system, the QNMU recommended the establishment of an independent Health Performance Commission. This commission would be a federal independent body to gather, analyse and report on data that enables value-based health care. Data from IHPA including who can access it and My Health Record data would fall under the auspices of this body.

What analysis using public hospital data should IHPA publish, if any?

QNMU supports the publication of analysis of the public hospital data, provided it is evidence-based and founded on rigorous research methods.

What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

The QNMU is supportive of the use of the Modified Monash Model (MMM) as the geographical classification system, developed by the Department of Health in 2015 (National Rural Health Alliance, n.d.). The federal government uses this system and it is based on up-to-date population data to address the distribution of medical services across Australia (Department of Health, 2018). It is for this reason the QNMU asks IHPA to consider the MMM in their review of geographical classification systems.

What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?

The QNMU asks IHPA to consider mental healthcare including acute care and rehabilitation and/or recovery. Payments should be linked to a patient to cover both inpatient and outpatient services. Input from across jurisdictions should be incorporated to distinguish phases of care.

Another area of the National Pricing Model to consider is health services for those who live in rural and remote Australia. Those who choose to live in these locations should not be disadvantaged in access to or quality of healthcare.

The QNMU has also recommended in previous submissions to IHPA bundled price for maternity care. We iterate this point as we believe midwifery continuity of care models provide optimal outcomes for women and their babies which has been demonstrated in large bodies of current research (Sandall, et al., 2013). This funding model could be the driver for incentivising a DRG that is woman-based and one that is not wholly an obstetrics model but encompasses midwife-led models of care.

What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?

Any adjustments made by IHPA to NEP19 should be based on meaningful and up-to-date data.

Further, we reiterate our views from previous submissions to IHPA regarding the importance of including nursing and midwifery-led programs when evaluating adjustments to the national efficient price (NEP). Establishing and maintaining safe workloads includes minimum nurse/midwife-to-patient ratios. Those health facilities that have these ratios should not be

penalised. Current research has proven safe nurse/midwife-to-patient ratios in conjunction with a higher proportion of nurses and better practice environments improves patient satisfaction, lowers mortality rates, decreases readmission rates and reduces adverse events such as infections, pressure injuries and postoperative complications (Twigg, et al., 2013; Lankshear, Sheldon, & Maynard, 2005 & McHugh, Berez, & Small, 2013).

Palliative care is also a priority area IHPA could consider when evaluating adjustments to NEP19. The benefits of palliative care compared with those receiving usual care show that there are less hospitalisations, shorter lengths of hospital stay, reduced use of intensive care units and fewer visits to emergency departments for those who are receiving palliative care services (National Centre for Social and Economic Modelling, 2017). Recognition of the role that palliative care has in enhancing value in healthcare and the quality of life for those people receiving these services could be considered by IHPA in the NEP19.

What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

We believe patients should be given the opportunity to choose the health service and health provider they wish. To achieve this, health services must be equitably opened to all health providers, including nurses and midwives, working in the area. This will allow the patient to decide where they want to receive health care and treatment, how they want to receive treatment and who they want to receive the treatment from. If the patient wants to see a nurse/midwife-led group they should be able to. There should be no restrictions as to the care a patient wants to receive. Models of care and other healthcare innovations must not be limited or restricted by narrow funding criteria.

Do you support price harmonisation for the potentially similar same-day services which are discussed above?

At present, the QNMU cannot support price harmonisation for similar same-day services. While the services provided are largely out-patient services, they are clinically diverse. However, if all key stakeholders are consulted and further investigation shows price harmonisation is warranted, then the QNMU's position may change.

An objective for price harmonisation should be that it will facilitate best practice and enable a range of health practitioners, including nurses and midwives, to provide healthcare services. We would extend this to include that price harmonisation be based on the principles of value-based healthcare model. This framework has the overarching goal of value for patients which the QNMU supports (Porter, 2010).

When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?

The QNMU believes IHPA should implement a shadow period after the full implementation of My Health Record.

Do you support the proposal to phase out the private patient correction factor for NEP20?

The QNMU is neither in favour nor in opposition of the proposal to phase out the private patient correction factor for NEP20. However, we believe wider consultation should be undertaken particularly with people who live in rural and remote Australia and the impact this change may have on their access to healthcare. IHPA may consider using the Modified Monash Model as a geographical classification model to use for these patients and their access to healthcare.

What other models might IHPA consider in determining funding for small rural and remote hospitals?

The QNMU asks IHPA to consider funding for midwife-led models of care for rural and remote hospitals. Those who choose to live in these locations should not be disadvantaged and should have the choice to engage in midwife-led models of care. These models are evidence-based and focus on woman-centred care being delivered by a primary midwife from early in pregnancy, throughout pregnancy labour and birth, to six weeks post birth.

There are several benefits to midwife-led continuity of care for women including a significant reduction in interventions such as epidurals, episiotomies and instrumental births as well as a reduced likelihood of preterm birth or losing their baby before 24 weeks gestation (Sandall et al., 2013). Numerous studies have established there are no identified adverse effects of midwife-led continuity of care when compared with models of medical-led care and shared care (Sandall et al., 2013). Further, readmission rates are reduced when midwifery models of care are used (Coyne, et al. 2016).

What countries have healthcare purchasing systems which can offer value in the Australian context and should be considered as part of the global horizon scan?

The QNMU supports any systems that are value-based health systems. The World Economic Forum & Boston Consulting Group (2017) urged the global healthcare community to see value-based healthcare as an opportunity to deliver outcomes that matter to patients and to society in a financially sustainable manner. The QNMU asks IHPA to consider value-based healthcare be included in their environmental scan.

Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network (either to the same hospital or to another hospital within the same Local Hospital Network)?

The QNMU appreciates the complexity of pricing and funding models for avoidable hospital readmissions. However, we believe patients should have the choice to attend any hospital of their choosing. There must be no restrictions placed on patients on the hospital they wish to attend.

The use of My Health Record as the unique identifier may alleviate issues around unique patient identifiers once it has been rolled out.

Do you prefer an alternative scope for measuring avoidable hospital readmissions and, if so, how would this be measured?

Incentivising evidence-based care to reduce avoidable hospital readmissions is crucial. One method to achieve this is to widen the collection of data. This would provide the evidence on what works in reducing avoidable hospital readmissions. For example, monitoring breastfeeding rates shows that breastfeeding is a protective factor against hospital readmission (Lundberg, et al. 2016). This is just one example of how expanding the scope for measuring avoidable hospital readmissions to capture more data, provides the evidence on how to reduce these avoidable hospital readmissions.

If the aim is to reduce all avoidable readmissions then expanding the collection of data would be part of this objective. The tracking of health outcomes including avoidable hospital readmissions and the costs involved, is fundamental in value-based healthcare delivery (World Economic Forum & Boston Consulting Group, 2017).

What are the advantages and disadvantages of use of the Medicare PIN and/or the Individual Healthcare Identifier for the purposes of pricing and funding of hospital readmissions?

The QNMU recommends the use of the Individual Healthcare Identifier for the purposes of pricing and funding of hospital readmissions as it is used as part of My Health Record (Department of Human Services, 2018). With the commitment made by the Council of Australian Governments (COAG) Health Council in August 2017 to deliver a My Health Record for every Australian by 2018, it is appropriate to support this strategy and the use of the Individual Healthcare Identifier (Australian Digital Health Agency, 2017).

Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions?

The QNMU agrees with the proposal to include funding options for avoidable hospital readmissions. This approach aligns with value-based healthcare which the QNMU supports.

What patient-specific factors should be examined in a risk-adjustment approach to avoidable hospital readmissions?

The QNMU views this as a slippery slope if patient-factors are examined in a risk-adjustment approach. Healthcare and access to healthcare is for all and not just those who are 'easy to treat'.

The QNMU acknowledges that IHPA notes the Australian Commission on Safety and Quality in Health Care excluded high-risk patients with complex and chronic conditions in their list of avoidable hospital admissions. However, the QNMU asks IHPA to consider those patients who have chronic and complex conditions. Cherry picking of patients which evades those more complex and those at risk of being more 'expensive' or at a greater risk of being a hospital readmission must be avoided (Australian Healthcare & Hospitals Association, 2015).

There is a need for flexible treatment plans to cover comorbidities and patient complexity to ensure avoidable hospital readmissions. With around 1 in 4 (23%) Australians having two or more chronic conditions such as arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health, this patient-specific factor should be examined (Australian Institute of Health and Welfare, 2018). Further, 1 in 2 (50%) Australians had at least one of these conditions and were involved in 37% of hospitalisations in 2015-16. With these chronic conditions attributed to most deaths in Australia, this signifies a heavy impact on the Australian healthcare system and one IHPA my need to examine (Australian Institute of Health and Welfare, 2018).

Funding options for avoidable hospital readmissions.

The QNMU will provide a general response to the questions on funding options proposed by IHPA.

We suggest consideration be given to a number of issues regarding funding models for avoidable hospital readmissions. These include:

- they should not be to the detriment of the patient;
- they must be timely and cost-effective;
- data collection must be accurate, transparent, maintained and trended;
- they should be evidence-based and grounded on models that show the limiting of avoidable hospital readmissions. These include nursing and midwifery models of care

that have proven to reduce readmissions. Studies have shown adequate nursing levels reduce readmission rates and is a cost-effective patient-safety intervention (Twigg, et al., 2013 & Weiss, Yakusheva & Bobay, 2011). Further, nurse navigators are being positioned in Queensland Health in the hospital and health services to help reduce unplanned readmissions to hospital (Queensland Government, 2018).

The QNMU also suggests that perhaps different states could trial one of IHPA's suggested funding options for avoidable hospital admissions. Data could be collected on each of the models from each state and this evidence could be used to inform IHPA's direction on which funding model to use on avoidable hospital readmissions.

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