Queensland Nurses & Midwives' Union

Submission to Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2020-21

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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 (QH) 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 60,000 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 relevant 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 and which offer viable alternatives to existing arrangements; and
- bundled pricing in maternity services.

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

The QNMU welcomes IHPA's proposal to promote value in public hospital services and support alternative funding solutions that deliver high quality care and focuses on patient outcomes.

We consider the Pricing Guidelines are still relevant. We suggest IHPA distribute these guidelines to the various regulatory agencies for health and aged care such as the Aged Care Quality and Safety Commission (ACQSC) and the Australian Commission for Safety and Quality in Health Care (ACSQSC). Regulators should work in collaboration with agencies such as IHPA so the focus is on consistent patient outcomes across the health and aged care sectors.

Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support 'value' in hospital and health services?

The QNMU has consistently sought innovation and value in delivering high quality patient outcomes, however we suggest the proposed addition also refer to the patient experience, an important aspect of the total journey.

What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?

As IHPA migrates to version 11.0 we suggest it mitigate any problems with previous versions and takes into account relevant government policy.

Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

The QNMU would like to see the inclusion of alternative models of care e.g. Nurse Practitioner led models and Midwifery Group Practice to enable nurses and midwives to work to their full scope of practice. We see greater integration of these models will add value and reduce costs.

We note in Section 4.4.2 of the discussion paper, IHPA shadow priced medical led multi-disciplinary case conference (MDCC) service events in NEP19 but was not able to shadow price nursing, midwifery or allied health led MDCC due to insufficient data. IHPA has indicated it will continue working with states and territories to obtain this data. We support this move and seek greater funding recognition for the work of nurse navigators (discussed further on).

Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

We note here that emergency departments (EDs) remain under considerable pressure caused in part by the large number of elderly Australian being transferred from the aged care sector.

Nurse practitioner led models of care that meet a particular catchment area may fast track patients through EDs. Outreach services by the acute sector (funded) and pressure on aged care providers to implement appropriate primary care services could be anticipated to reduce some pressure on EDs.

Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

We seek a review of the Australian Mental Health Care Classification (AMHCC) that considers an alternative funding model for diagnoses of people with less serious symptoms of conditions such as substance abuse, anxiety and depression. The class for funding does not currently provide inpatient care for less acute mental illness that has the potential to become severe if left untreated.

These conditions have a high risk of deterioration and the person may end up in a public hospital later with a much more serious illness or after attempted suicide or non-suicidal self-injury. The QNMU believes the current approach is a form of false economy, with a model of early intervention likely to have financial and human cost benefits.

There is significant evidence that indicates psychological therapies can reduce suicidality and promote wellbeing in all age groups and across a range of diagnoses including depression, bipolar disorder, schizophrenia and borderline personality disorder (Zalsman et al., 2016).

Effective pharmacological and psychological treatments of depression are important in suicide prevention. Insufficient evidence exists to assess the possible benefits for suicide prevention of screening in primary care, in general public education and media guidelines. Other approaches that need further investigation include gatekeeper training, education of physicians, and internet and helpline support (Zalsman et al., 2016).

Mental health-related services are provided in Australia in a variety of ways, including:

- admitted patient care in hospital and other residential care;
- hospital-based outpatient services;
- community mental health care services;
- consultations with both specialist medical practitioners and general practitioners (GPs).

State and territory governments fund and deliver public sector mental health services that provide specialist care for people with severe mental illness. These include specialised mental health care delivered in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services (AIHW, 2019).

The Australian Government funds a range of mental health-related services through the Medicare Benefits Schedule (MBS), and the Pharmaceutical Benefits Scheme (PBS)/Repatriation Pharmaceutical Benefits Scheme (RPBS). The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness (AIHW, 2019).

Mental health non-government organisations receive government and/or private funding. Generally, these services focus on providing well-being, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically focused services (AIHW, 2019).

Private sector services include admitted patient care in a private psychiatric hospital and private services provided by psychiatrists, psychologists and other allied health professionals. Private health insurance funds treatment costs in private hospitals, public hospitals and out of hospital services provided by health professionals (AIHW, 2019).

Although there are various levels and types of support, many people without private health care cannot afford to access private sector services. In our view, the hospital funding model should reflect demand and capacity to treat less serious mental health conditions as public hospital inpatients before they exacerbate and become more costly in the long term.

Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

At present, there are challenges in the funding model around the 'unqualified' newborn. A total of 309,142 births were registered in Australia in 2017 (ABS, 2018). Many 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.

Neonatal care for qualified babies includes care of newborns who are suffering from illness or disability and could involve many aspects of monitoring, oxygen therapy, administration of

IV drugs and post surgical care. Evidence indicates the mother and baby dyad should remain together where possible (Queensland Health, 2013). 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 creates additional work for the midwifery staff, for which health services are not funded.

Methodologies to fund care of newborns need to be considered urgently. 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.

It is a sad reality the Coroners Court considers the newborn as a separate entity yet funding models do not unless the newborn is 'qualified' (Office of the State Coroner, 2007; Office of the State Coroner, 2011).

Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

If taxpayers are paying for private patients from the public purse providers should be required to publish all data. Transparency and reporting in funding are essential.

Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

The QNMU has consistently supported public reporting of health data that will enable consumers to make informed choices and to hold health providers accountable for the public purse.

Research (Chen, 2010; Hibbert et al., 2013) indicates public disclosure of performance data stimulates quality improvement activity at the hospital level, largely because institutional reputations are at stake. Reporting against patient quality and safety indicators is one way in which providers can drive performance. Reporting alone is not sufficient if it is not published.

Public and private hospitals already participate in clinical indicator programs run by accrediting bodies such as the Australian Council on Healthcare Standards (ACHS). These indicator programs would provide a useful starting point for hospital wide and clinical specialty indicators that may be suitable.

We also believe the top ten Australian Refined Diagnosis Related Groups (AR-DRGs) for each facility would be valuable public knowledge as they provide a clinically meaningful way of

relating the number and type of patients treated in hospital and the resources required by the hospital (Australian Institute of Health and Welfare, 2018).

Other indicators that should be publicly available include:

- Patient Reported Outcome Measures (PROM);
- Patient Reported Experience Measures (PREM);
- Average length of stay;
- Readmission rates;
- Post-surgical mortality rates;
- Adverse advents;
- Healthcare-associated infections;
- Presentations to emergency departments;
- Waiting and treatment times in emergency as well as the proportion of patients staying for four hours or less;
- Elective surgery waiting and treatment times;
- Perinatal indicators such as premature births, planned and unplanned caesarean sections, breastfeeding and access to continuity models of care (which are known to positively impact these outcomes).

The QNMU believes expanded reporting of public and private hospitals and the aged care sector must include the costs to the patient for the health service. Certainly, the respondents in the Consumers Health Forum of Australia (CHF) (2018) survey strongly supported the establishment of a website where patients can consult to determine the costs they will need to pay for a hospital service. While we acknowledge the difficulty in providing costings for all procedures and services, we believe a website can provide:

- The average prices for common hospital procedures;
- Costs per day for uninsured patients;
- Out-of-pocket expenses;
- The type of arrangement the hospitals have with each health fund and whether the health funds will fully or partially cover costs relating to the hospital fees and
- Model of Care information. For example, the Maternity Care Classification System (MaCCS) developed as part of the National Maternity Data Development Project to classify, record and report data about different maternity models of care should be available to make visible the link between models of care and outcomes.

Should a national PROMs collection be considered as part of national data sets?

The QNMU supports a national collection of PROMs**.** Along with PROM, patient reported experience measurement (PREM) needs more prominence. A systematic review of 55 studies found patient experience is consistently positively associated with patient safety and clinical effectiveness across a wide range of disease areas, study designs, settings, population groups and outcome measures (Doyle, Lennox & Bell, 2013). A value-based approach to healthcare places the patient's experience and outcomes at the centre of health system (discussed below).

Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

The QNMU supports health systems that are value-based, transparent and focused on outcomes. The World Economic Forum (WEF) & 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.

Value in health care has been defined as the health outcomes that matter to patients relative to the resources or costs required (WEF 2017). This reflects the seminal work of Porter and Teisberg (2006).

The health outcomes that matter are multidimensional, including factors much broader than traditional clinical indicators. The resources or costs must reflect the actual costs of the care delivered to a patient over a full cycle of care. This recognises that a patient's full course of care can be provided by multiple providers and over a period of time involving multiple episodes of care.

A value-based approach to health care provides a patient-centric way to design and manage health systems; it offers a frame of reference for dialogue between stakeholders when working towards improving value delivered to a defined patient group or segment of the population (Woolcock, 2019).

Alignment with a value-based approach to health care was assessed by the Economist Intelligence Unit (EIU) (2016) for 25 countries, including Australia. A country's alignment was considered with reference to progress in:

- Enabling context, policy and institutions for value in health care (8 indicators);
- Measuring outcomes and costs (5 indicators);
- Integrated and patient-focused care (2 indicators);
- Outcome-based payment approach (2 indicators).

Woolcock (2019) makes five recommendations for enabling value-based health care through public policy in Australia. These include:

1. A national, cross-sector strategy for value-based health care in Australia;
2. Access to relevant and up-to-date data;
3. Evidence for value-based health care in the Australian context;
4. Health workforce strategies supporting models of care that embrace a value-based approach;
5. Funding systems that incentivise the delivery of value-based health care.

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

The QNMU recommends IHPA align bundled pricing to evidenced-based models of care to direct and reinforce the implementation of best practice in public health services. The focus on cost and outcomes in maternity care in the 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 (Miller et al., 2016; Shaw et al., 2016). Midwifery models of care, and potentially other evidence-based innovations in maternity care, could be well supported by the introduction of bundled payments.

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; Homer, 2014; Renfrew, 2014; ten Hoope-Bender, 2014). Further, readmission rates are reduced when midwifery models of care are used (Coyne, et al. 2016).

Therefore, we support 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 promote the continual improvement and delivery of safe, high quality healthcare.

All stages of maternity should be included. Antenatal and postnatal care are easily defined and could be bundled separately i.e. 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.

Potential included/excluded patient groups need more extensive consideration. The inclusion of most women is possible through bundling uncomplicated care and vaginal birth although there may be a need to include a caveat (i.e. all women under 39 with an uncomplicated birth).

The exclusion of those experiencing antenatal and postnatal care outside the hospital setting such as those in shared care arrangements with GP's, 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 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) would assist in providing most efficient models of funding and data collection but would require extensive work. IHPA could make this recommendation to government/s as 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.

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 and not the unqualified/unadmitted baby). This creates a disincentive to safe staffing. Policy changes around newborns have increased the amount of care a newborn requires even where that newborn is considered relatively low risk (Queensland Health, 2013). For example, in Queensland the unqualified baby who is not counted in funding or workloads has 11 separate statewide clinical guidelines attached to her/him and five sets of documentation generated by the midwife at a minimum.

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.

Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

The QNMU supports a funding model that focuses on prevention rather than punishment. A punitive approach may lead to a culture of under-reporting or non-reporting amongst clinicians in order to avoid adverse consequences and reduced funding. Improving safety and quality should be the result of reward for good outcomes through best practice and innovation. To that end, we support sharing comparative data to drive clinical changes that decrease low value care.

Funding that incentivises best practice provides an opportunity for hospitals to display positive attributes which may assist with system change. There is potential for funding penalties to add to system challenge and to cause more negative outcomes such as restrictions on staffing numbers and other resources.

The following case study demonstrates the significant positive outcomes for government, consumers, nurses and other clinicians when QH introduced nurse-to-patient ratios. This was the first prospective study of a nurse-to-patient ratios policy globally.

Case Study – Nurse to Patient Ratios

In July 2016, QH introduced nurse-to-patient ratios in 27 public hospitals. The findings of research into the impact of this initiative by the University of Pennsylvania School of Nursing has recently been presented at the 2019 International Nursing Conference in Singapore. The study found the reduction of one patient per nurse was associated with:

- 9% lower odds of dying in the hospital;
- 6% lower odds of readmission within 7 days;
- 3% reduction in length of stay; and
- 7% reduction in nurse burnout.

This equates to 145 deaths avoided, 225 readmissions avoided (saving around $2.2 million US) and 29,222 hospital days avoided (saving around $20 million US).

The evidence suggests policies establishing safe nurse staffing standards improve patient and nurse workforce outcomes and provide savings from avoided readmissions, shorter length of stay and fewer complications (Aiken & McHugh, 2019).

The introduction of 400 nurse navigators in QH provides another important example of innovation as a means of reducing costs for both consumers and the health system. Nurse navigators are a team of registered nurses who provide a service for patients who have complex health conditions and require a high degree of comprehensive, clinical care.

These nurses are highly experienced and have an in-depth understanding of the health system.

The key principles of the nurse navigator services are:

- coordinating patient centred care;
- creating partnerships;
- improving patient outcomes;
- facilitating systems improvement.

Nurse navigators:

- use a multi-disciplinary approach to monitor high needs patients, identify actions required to manage their health care and direct patients to the right service, at the right time and in the right place;
- provide a central point of communication and engagement to ensure optimal care and coordination of services along a patient's entire health care journey;
- educate and help patients to better understand their health conditions and enable them to self-manage, participate in decisions about their health care and improve their own health outcomes (Queensland Health, 2015).

Nurse navigators support and work across system boundaries and in close partnership with multiple health specialists and health service stakeholders to ensure patients receive the appropriate and timely care needed. They are positioned throughout QH in the hospital and health services to help reduce unplanned readmissions to hospital. Their contribution should be factored into hospital pricing.

What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

Software should be able to better inform decisions but not in a punitive way. This causes more defensive practice and discourages innovation.

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 systems and practices to avoid hospital readmissions. For example, monitoring breastfeeding rates shows that breastfeeding is a protective factor against hospital readmission (Lundberg, et al. 2016). Expanding data collection to capture the contribution of nurse navigators is another means of providing evidence on measures that reduce avoidable hospital readmissions.

We suggest consideration be given to a number of factors related to 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 are a cost-effective patient-safety intervention (Aiken & McHugh, 2019; Twigg, et al., 2013; Weiss, Yakusheva & Bobay, 2011).

If the aim of software configuration 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).

The QNMU suggests different states could trial a funding option 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. Nurse navigators present a viable option for such a trial in Queensland.

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