Queensland Nurses & Midwives' Union

Submission to

Independent Hospital Pricing Authority (IHPA)

Consultation Paper on the 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 comment on the consultation paper on the pricing framework for Australian Public Hospital Services 2021-22.

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 classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), midwives (RM), nurse practitioners (NP) 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 64,000 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 in Queensland are members of the QNMU.

This year 2020 will be dedicated to celebrating the International year of the Nurse and the Midwife, in celebration of the 200th year anniversary of the birth of the founder of contemporary nursing, Florence Nightingale. The World Health Organisation (WHO) nominated Nurses and Midwives for their invaluable contribution to health care and to highlight the need for a strengthened Nursing and Midwifery workforce to achieve Sustainable Development Goals (SDG) and universal health coverage. The QNMU is proud to embrace this opportunity to invest in the Nursing and Midwifery professions, particularly the investment into minimum safe staffing ratios and skill mix across all health sectors.

The QNMU's submission responds to a subset of the consultation questions, with a particular focus on the following aspects as they relate to nursing and midwifery:

- Impacts and lessons learned through the COVID-19 pandemic
- Exploration of innovative funding models
- Value-based care as it represents a more consumer focused method of categorising healthcare to improve the quality of patient experiences and outcomes;
- Nurse and midwifery-led models of care that allow nurses and midwives to practice to their full scope; and
- Bundled pricing in maternity services.

What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?

Activity levels

The COVID-19 global pandemic has significantly disrupted the health care system. As a result, the QNMU has observed a significant decrease in activity levels influenced by the decrease in presentations to emergency departments, cessation of elective procedures and a shift in focus towards pandemic planning and preparedness processes (Grattan Institute, 2020).

Health care systems have been required to remain agile to manage potential surges in COVID-19 patients and anticipate a significant backlog of surgical work, delayed access and late presentations to hospital and health services (Lynn et al., 2020). Usual primary care practices including prevention, screening early detection and patient monitoring have been cancelled, postponed or converted to telemedicine as part of the pandemic response (Wright et al., 2020). As health care systems focus on treating affected patients and infection control measures, there is a risk of surges in patients with delayed diagnosis and treatments (Wright et al., 2020). Retaining an expanded nursing and midwifery workforce is vital in order to deal with potential surges in COVID-19 and non-COVID-19 related health care demands. The QNMU continues to advocate for all classifications of nurses and midwives to expand nurse-led, midwife-led models of care to their full scope of practice beyond the pandemic, to improve health care delivery and patient outcomes.

Models of Care

The COVID-19 pandemic has further emphasised the critical role that nurses and midwives play in health care delivery and patient outcomes. The QNMU acknowledges that whilst the COVID-19 pandemic has caused mass devastation, there is a distinct opportunity for change. The skills and experience of nurses and midwives can be enhanced through implementing innovative models of care, enabling nurses and midwives to work to their full scope of practice, revising standards of care, workforce capacity and workforce design and health and safety standards across all sectors post COVID-19. Nurse-led and midwife-led models of care ensure a more accessible, productive and safer health and aged care systems.

The QNMU considers that significant opportunities also exist to enhance access and responsiveness via the use of technology, and as demonstrated during the pandemic. Nurses and midwives are well positioned to advance technology enhanced care. Further consideration and support should be given to nurses and midwives to support the optimal utilisation of technologies within health care, including the application of artificial intelligence in health settings, given the pivotal role nurses and midwives pay in care coordination and keeping our health system “human”. The use of technology enhanced care, such as telehealth, improves provisions of health services and offers the potential to address many health systems issues during and after the COVID-19 pandemic (Monaghesh & Hajizadeh, 2020).

The QNMU seeks greater funding recognition for innovative nurse and midwifery-led models of care. We wish to highlight the following models of care that have been utilised during the COIVD-19 pandemic response.

Nurse Navigators

Nurse navigators are an example of a flexible workforce that successfully adapted to the changing demands of the Queensland health care systems throughout the COVID-19 pandemic response. Nurse navigators played an integral role in protecting vulnerable clients with multiple co-morbidities and chronic respiratory conditions, whilst managing their usual caseloads. Initially, some Hospital and Health Services (HHS) deployed nurse navigators to lead fever clinics. Many nurse navigators responded with innovative solutions such as coordinating care in the community, partnering with primary care networks, community-based health teams and other services. Key examples of nurse navigator's flexibility are the development of virtual models of care in the community, enhancing Hospital in the Home (HITH) and Hospital in the Nursing Home (HINH) models. These models were highly successful in keeping vulnerable populations outside of the acute hospital system during this crucial time. The advancement of such models will greatly support the necessary shift to a better integrated and high value health system.

Nurse Practitioners

The QNMU advocates for the expansion of the nurse practitioner workforce to provide additional surge capacity for future COVID-19 and other emergency response needs. Nurse practitioners can operate independently to prescribe, order tests and provide cost-effective care for patients. The QNMU suggests the need for an active plan to identify roles for nurse practitioners and support for education for candidates and funding and recruitment into roles. We encourage IHPA to consider alternative models of care such as the use of nurse practitioner-led models to enable nurses to work to their full scope of practice. In our view, greater integration of these models will add value, support health system integration and reduce costs.

Telehealth

The COVID-19 response has required many health services and health professionals to transition to telehealth models of care. Whilst telehealth does not replace the importance of human connectedness or the need for appropriate face-to-face appointments and clinical examinations, the value for telehealth in the right context is considerable.

Hospital in The Home (HITH)

The pandemic has necessitated a transition to hospital avoidance models of care, to reduce surges in demand for hospital services. Hospital in the Home is a service that has been adopted in QLD to support patients, particularly in residential aged care facilities, to avoid unnecessary hospital admission or re-admission, and potential exposure to COVID-19. The role of nurses is critical in coordinating care across acute and non-cute settings and providing

communication between patients, families, aged care residential facilities and primary health services.

Midwifery

The QNMU wishes to acknowledge the important role that midwives have played in supporting pregnant and birthing women during the pandemic. COVID-19 has significantly impacted the way midwifery services have been delivered. Midwifery funding models have provided a vital opportunity to deliver care and maintain continuity throughout these unprecedented times. The implementation of electronic prescribing and the introduction of the home delivery services of Pharmaceutical Benefit Scheme (PBS) and Repatriation Schedule of Pharmaceutical (RPBS) medications during the pandemic, have enabled midwives to continue providing medicines to patients. Further measures such as increasing bulk-billing incentives and adding pathology diagnostics for COVID-19 screening as billable Medicare Benefits Schedule (MBS) items have also been a valuable strategy. Such strategies enable care outside of the hospital setting, that is crucial to reduce the risk of COVID-19 infection and placing further emphasis on public safety.

The QNMU recommends expanding the Council of Australian Governments s19(2) exemptions initiative to include all geographical areas in Australia, not just in rural and remote localities (Department of Health, 2020). This expansion would enable midwives and nurses to work to their full scope of practice within community-based services, reducing the need for intervention from general practice clinics or hospital care (Department of Health, 2020). The QNMU advocates for the expansion of the MBS items available for nurses and midwives working in private practice and primary care settings.

What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?

The QNMU cautions against the potential for the National Pricing Model creating incentives for public hospitals to admit private patients, as this could interfere with public patients having adequate access to health care. The QNMU advocates for equitable access to health care services and cautions against the use of private patient revenue in the public system. This is a particular concern with regards to the potential surges in COVID-19 patients and non-COVID-19 related demands for health care. As such, the QNMU suggests that IHPA consider incentives that improve health service delivery and access to care through innovative nursing and midwifery-led models of care.

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

The QNMU welcomes IHPA's efforts to identify alternative funding solutions that deliver high quality care and focuses on patient outcomes. The QNMU also supports IHPA's consideration of the need for innovative funding models to be financially neutral regardless of whether

patients elect to be public or private. We also express support for a sustainable public hospital network to ensure equitable access to health care. The QNMU promotes the need for an effective, efficient and value-based health system that is affordable and meets the growing needs of Queenslanders. In our view, the Pricing Guidelines are still relevant. However, we consider the need to further develop funding models that are value-based rather than activity based. We encourage IHPA to distribute these guidelines to various regulatory agencies for health and aged care, including the Aged Care Quality and Safety Commission (ACQSC) and the Australian Commission for Safety and Quality in Health Care (ACSQSC). In the opinion of the QNMU, regulators should work in collaboration with agencies like IHPA to ensure consistent patient outcomes and standards across the health and aged care sectors.

How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

The QNMU supports the development of pricing for community mental health services to transition to shadow pricing. However, the QNMU encourages the need for access to adequate data, that will inform evidence-based pricing. As such, we support IHPA's commitment to work with states and territories to expand the availability of data to be used for pricing in the future.

In our view, increasing data availability will also provide for greater funding recognition for the work of nurse navigators.

Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

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).

The Australian Government funds a range of mental health-related services through the 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).

The QNMU strongly recommends 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. The QNMU views these conditions as having a

high risk of deterioration and more acute mental illness by the time they present to a hospital, for instance after an attempted suicide or non-suicidal self-injury. The QNMU encourages the need for an early intervention and prevention model that addresses mental illness prior to patients presenting with serious illness or injuries. In our view, a prevention model is likely to be more cost effective and provide better outcomes for patients. For many, access to mental health services can be difficult and costly for those without private health insurance who cannot afford access to private sector services. The QNMU recommends the need to enhance universal early intervention and prevention mental health services and models in the public sector as the system is currently structured and funded to support the wealthy.

The QNMU supports IHPA in continuing to develop an approach to pricing for mental health care that is evidence-based. We believe that the pricing model should consider the complexity and risks of mental health care and expand aspects of health care to include acute, rehabilitation, and recovery in pricing models.

The QNMU believes that effective pharmacological and psychological treatments of depression are important in suicide prevention. Evidence indicates that 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). However, further research is required to identify effective suicide prevention models and evidence-based approaches, in order to accurately price admitted mental health care.

Do you support the adjustment IHPA has proposed for NEP21?

The QNMU supports the need to make an adjustment for transport in rural areas, including medical transfers and other inter-service transports in rural areas, including medical transfers and other inter-service transports in rural areas. The QNMU views the adjustment as an opportunity to improve access to health services and bridge the health inequity gap for patients living in rural localities. We believe that better use and investment into telehealth services is required for populations living outside of metro areas. Greater funding of telehealth services is required, where specialists and GPs encourage active involvement of patients in their care, to build skills and capacity in the rural generalist medical workforce.

Are there other clinical areas where introducing price harmonization should be considered?

The QNMU believes that an objective for price harmonisation should be to facilitate best practice and enable nurses and midwives to provide adequate health care services. The QNMU encourages IHPA to base price harmonisation on the principles of value-based healthcare. The QNMU has long advocated for a value-based model as it places the focus on patients and patient outcomes (Porter, 2010).

What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

Bundled Pricing

The QNMU recommends bundled pricing for maternity care as there is a significant body of evidence to support that midwifery continuity of care models improve outcomes for patients (Sandall, et al., 2013).

There are challenges with the current funding model around the 'unqualified' newborn. In 2017, there was a total of 309,142 births registered in Australia (ABS, 2018). Funding models do not recognise a newborn a separate entity unless the newborn is 'qualified'.

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

Qualified babies can receive neonatal care where newborns are suffering from an illness or disability and could involve monitoring, oxygen therapy, administration of IV drugs or post-surgical care. 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. The QNMU considers the need for a review of funding models to provide care to newborns. Funding for inpatient postnatal care must include a separate allocation of the newborn. Alternatively, funding for the mothers should be increased to account for the increased workload generated by the care of mother and baby.

Currently, most hospital staffing models are based on the number of inpatient mothers, whereby only the mother's care is funded. In our view, this funding model can lead to unsafe staffing practices. The QNMU believes that bundled pricing for maternity services could be used to provide an incentive for hospitals to practice evidence-based care and improve the safety and quality of care delivered to mothers and babies.

We continue to support the need for newborn care within the scope of the bundled pricing approach. The increased acuity of mother's results in increased demand on care requirements for an unqualified baby. Recent policy changes have also increased the required care for newborns, even if they are deemed low risk (Queensland Health, 2015).

Evidence indicates that midwifery-led continuity of care models for women provide a range of benefits including a 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). Evidence also suggests that midwifery models of care can lead to a reduction in readmission rates (Coyne, et al. 2016). The QNMU recommends that all stages of maternity care should be eligible for bundled pricing, however antenatal and postnatal care could be bundled separately. We believe that separate bundled pricing will enable flexibility in costing and funding arrangements.

The QNMU acknowledges that included and excluded patient groups eligible for midwifery bundled pricing requires further exploration. However, bundling uncomplicated midwifery care and vaginal births will allow for the inclusion of the large majority of women. The QNMU encourages IHPA to explore the inclusion of antenatal and postnatal bundling outside of the hospital setting (i.e. community maternity care and services) to provide greater access to bundled pricing. This is a potentially useful funding model, given the uptake of community maternity care during the COVID-19 pandemic.

The QNMU recommends that IHPA consider aligning bundled pricing with evidence-based models of care to reinforce the implementation of best practice in public health services. We believe that midwifery models of care could be well supported by the introduction of bundled payments. The QNMU also recommends that IHPA consider funding for midwifery-led models of care in rural and remote locations. We believe that funding models should work to reduce health inequities faced by population living in rural or remote locations.

What other strategic areas should IHPA consider in developing a framework for future funding models?

Value-based health care

As previously mentioned, the QNMU supports the transition to value-based health care and funding model. The QNMU recognises that the current pricing guidelines are aligned with an Activity Based Funding (ABF) model, which IHPA has identified as a challenge for implementing alternative funding models. However, re-shaping the focus of health care systems to generate value for patients by improving outcomes, quality improvement and reducing costs will ultimately benefit patient care at the individual and population levels (Teisberg et al., 2020). The QNMU recommends a cultural shift is required to put patients at the forefront of health care. In our view, there needs to be a reassessment of our current funding models. IHPA should consider transitioning to a value-based model, to achieve improved patient outcomes long-term.

Value-based care encompasses health outcomes that are much broader than traditional clinical indicators. The resources or costs must reflect the actual costs of the care delivered to patients across the total course of care. This can be provided by multiple providers across multiple episodes of care (Teisberg et al., 2020).

Nurse-to-Patient Ratios

In July 2016, Queensland Health introduced nurse-to-patient ratios in 27 public hospitals. The evidence suggests that establishing safe nurse staffing standards improve patient and nurse workforce outcomes and provide savings from reduced avoided hospital readmissions, shorter length of stay and fewer complications (Aiken & McHugh, 2019). The QNMU views mandated ratios across all nursing and midwifery sectors as a key funding model to consider.

Nurse Navigators

As earlier mentioned, nurse navigators offer a vital role in the coordination of health services. Nurse navigators support and work across system boundaries and in close partnership with multidisciplinary teams and health service stakeholders to ensure patients receive the appropriate and timely care needed. Nurse navigators approach patient care with a high level of coordination and in-depth understanding of health systems, across a broad continuum of care. The role provides a centralised point of communication for patients to ensure the quality and consistency of healthcare for patients. In addition, the role provides education to improve patient's health literacy and support for patients to autonomously manage their health and health outcomes (Spooner et al., 2019). Nurse navigators have the potential to improve service integration, supporting the transition between acute and continued care (McMurray & Cooper, 2017). As such, the QNMU believes that nurse navigators should be included in future funding model frameworks.

Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

The QNMU believes that the implementation of innovative funding models is critical to health care delivery and outcomes. In order to implement a value-based model of funding, a strong national leadership strategy and cooperation is required from all jurisdictions to implement a national value-based funding system that focuses on patient outcomes first.

The QNMU considers the following critical success factors required to implement a value-based funding model:

- Creating partnerships with patients to support genuine co-design of services so that care remains patient focused (Woolcock, 2019)
- Identifying measurable outcomes in partnership with patients
- A national, cross-sector strategy for value-based health care in Australia
- Health workforce strategies supporting models of care that embrace a value-based approach (Woolcock, 2019)
- Funding systems that incentivise the delivery of value-based health care (Woolcock, 2019)
- Access to relevant and appropriate data

- Appropriate evaluation mechanisms

Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

The QNMU expresses general support for the proposed funding option one for avoidable hospital readmissions. Reducing the rates of avoidable hospital readmissions could significantly impact and improve hospital outcomes, which in turn improves hospital efficiency and cost effectiveness.

What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

The QNMU suggests funding adjustments for avoidable hospital readmissions should be evidence-based, timely and cost-effective.

The QNMU asks that IHPA consider the following aspects when implementing a funding adjustment for avoidable hospital readmission:

Nurse Navigators
Nurse Navigators are positioned throughout Queensland Health in the hospital and health services to help reduce unplanned readmissions to hospital (Queensland Government, 2018). The QNMU strongly encourages IHPA to factor Nurse Navigators into hospital pricing and guidelines.

Midwifery
The QNMU advocates for adequate funding for mental health services for mother and baby units and appropriate funding for midwives to work across public and private sectors, as this has been a barrier for midwives to deliver adequate care during the COVID-19 response.

Evidence-based approach
The QNMU supports an evidence-based approach to reducing avoidable hospital readmissions. In our view, improving data capacity will inform best practice approaches to reduce readmissions. For instance, the QNMU encourages capturing data that identified the contribution of nurse navigators in reducing avoidable hospital readmissions. 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 is aware that Queensland Health has commissioned a review of the pandemic response in Queensland to prepare advice to the Deputy Premier and Director General on how best to harness the opportunities for system reform arising from the pandemic response.

The Health Reform Group established to undertake this review and provide a "roadmap" for reforming the Queensland health system provided its report *"Unleashing potential: an open and equitable health system: Healthcare for Queenslanders in a pandemic ready world"* at the end of August 2020.

The group's recommendations aim to support an open, equitable and responsive health system to optimise the health of Queenslanders. The QNMU identifies a number of intersections between the issues currently being considered by IHPA and the Health Reform Group, given this review focused on supporting an integrated high value health system, workforce innovation and empowerment and accountable system governance and effective implementation of change.

Although this report has not yet been publicly released, the QNMU strongly recommends that IHPA contacts Queensland Health to ascertain when this report will be publicly available to consider the observations and recommendations made by this group as part of your consultation.

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