THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to

The Independent Hospital Pricing Authority

Pricing Framework 2016-17

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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 2016-17* (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 Queensland government. 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 more than 53,000 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 the following consultation questions set out in the paper.

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

The QNU welcomes IHPA's proposal to investigate the Modified Monash Model (MMM) as an alternative to the Australian Statistical Geography Standard (ASGS). The MMM categorises metropolitan, regional, rural and remote areas according to location and introduces new categories in regional and rural remoteness areas based on the size of the town.

In our view, a population-based method will be more effective in addressing the unavoidable costs of service delivery in remote locations. This approach offers a more equitable distribution of funds and may act as an incentive to attract health professionals into areas that are traditionally difficult to staff.

A population-based method where 'funding should follow the patient wherever possible' (p. 18) would also enable the proper implementation of minimum safe nursing and midwifery staffing levels as it provides for unwarranted cost variation. The workload allocation model for nurses and midwives in the Queensland public sector is the Business Planning Framework (BPF). For many years the QNU has sought the proper application of this scheme to ensure nurses have reasonable workloads that protect patient safety.

Clause B13 of the National Health Reform Agreement states that IHPA 'must have regard to legitimate and unavoidable variation in wage costs and other inputs which affect the costs of service delivery'. We draw IHPA's attention to the Queensland government's recent commitment to legislate to provide minimum nurse/midwife-to-patient ratios in the Queensland public sector.

We point out that changes to distribution categories may involve a consequential adjustment to current rural and remote incentive programs provided under industrial instruments such as the Remote Area Incentive Package (RANIP) for Queensland Health employees. As a union protecting the industrial rights of our members we are willing to discuss any changes, but would not be prepared to accept a reduction in existing entitlements. One of the first programmes to transition to the MMM will be the General Practice Rural Incentive Programme (GPRIP) (DoctorConnect, 2015). The outcome of this initiative may provide insight for transitioning other rural health professionals.

What are the priority areas for IHPA to consider when evaluating adjustment to National Efficient Price (NEP) 16?

The QNU supports continuation of the current adjustments set for NEP 15 to NEP 16. For NEP 16, IHPA will consider whether an adjustment is required:

- for all admitted patients with an intellectual disability;
- to improve services specific to CALD patients such as interpreter services;
- following further analysis of FIFO workers who are treated in outer regional and remote hospitals;
- for age-related adjustments in EDs.

We welcome each of these proposals. Queensland is the most decentralised Australian state, having a number of significant urban areas mostly on the coast (ABS, 2015). There is a large fly-in fly-out (FIFO) workforce and tourist population that creates variable patient flow and funding allocation according to patient area code of residency and not area code of health service presentation. Services such as health care, police, transport, water supply, garbage collection and sewerage, and infrastructure such as housing, roads, rail, airports and telecommunications can be inadequate if they are funded and built for the usually resident population but are actually used by a larger 'service' population (ABS, 2013).

For the period 1973-2013, greater Brisbane was the only capital city to decrease in share of state population, down from 51% to 48%. This reflects comparatively stronger growth in areas such as the Gold Coast and the Sunshine Coast (ABS, 2014). Thus a population-based model such as MMM may have potential to allocate funding more equitably and effectively.

Do you support IHPA's expanded policy intention for bundled pricing in future years?

The QNU supports IHPA's expanded policy intention for bundled pricing of selected health services **if** it is aligned with evidence-based models of care that demonstrate tangible benefits of this practice for both the consumer and healthcare provider and is inclusive of all service costs associated with the episode of care.

What services or patient episodes of care would most benefit from this expanded bundled pricing approach?

The QNU supports IHPA's enquiry into the feasibility of bundled pricing for stroke, joint replacement and in particular maternity services that promote midwife-led continuity models of care.

Midwife-led continuity models are based on woman-centred care and are associated with a primary midwife who provides care from early in pregnancy, throughout pregnancy labour and birth, to six weeks post birth. The primary midwife coordinates care for the woman, facilitates access to care that is more complex and other carers according to her needs.

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.

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).

What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

The QNU recommends that IHPA align bundled pricing to evidenced-based models of care to direct and reinforce the implementation of best practice in public health services. A focus on consumer outcomes and minimum datasets as per national and international standards is highly recommended to support the continual improvement and delivery of safe, high quality healthcare.

Consultation with key stakeholders such as consumer groups, clinicians, professional bodies and health services is deemed essential to ensure the applicability, legitimacy and appropriateness of the services included in a bundled price for any episode of care.

In relation to maternity services, the QNU suggests that IHPA reviews the applicability of bundle pricing for both uncomplicated and complicated maternity care services when delivered in midwife-led continuity care models as these models are suitable to women both at low and increased risk of complication. Current research has concluded that most women should be offered midwife-led continuity models of care, with caution being exercised only for women with substantial medical of obstetrics complications.

The QNU suggests that the following groups are added to any key stakeholder discussion regarding price bundling in maternity care services:

- Maternity Choices Australia;
- Australian College of Midwives;
- Midwifery and Maternity Providers Organisation Australia;
- Australian Nurses and Midwives Federation;
- Queensland Nurses' Union.

What implementation issues should IHPA consider when further investigating the feasibility of applying a best practice pricing approach in future years?

Prior to the Queensland state election held on 31 January, 2015, the QNU (2015) sought the commitment of all major political parties to:

- mandate and enforce via legislation and regulation standards minimum nurse/midwife-to-patient ratios and skill mix levels for Queensland Health facilities to act as a care guarantee in conjunction with the proper application of the BPF workload methodology;
- mandate and enforce via legislation and regulation standards minimum nurse/midwife-to-patient ratios and skill mix levels for acute private health facilities to minimise unwarranted service variation across Queensland;
- mandate and enforce via legislation and regulation standards the participation of public, private and aged care sectors in minimum nursing/midwifery data sets that monitor and openly report nurse/midwife ratios, skill mix levels and quality outcomes across Queensland;
- urgently review the adequacy of nurse numbers, skill mix and quality indicators in residential aged care facilities across Queensland to determine the parameters of safe staffing for the purposes of mandating minimum nurse-to-resident ratios and skill mix levels;

- mandate and enforce via legislation that a Registered Nurse is present on shift in residential aged care facilities at all times to improve the safety and quality of care delivery in parity with *New South Wales' Public Health Act 2010.*

Minimum nurse/midwife-to-patient ratios and endorsed skill mix levels are an economically sound method to save lives and improve patient outcomes. National and international studies have irrefutably proven the number, skill mix and practice environment of nurses/midwives directly affects the safety and quality performance of health services. 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. (Aiken et al., 2014; Tubs-Cooley et al., 2013; Lankshear et al., 2005; McHugh et al., 2013). These studies indicate:

- Every one patient added to a nurse's workload is associated with a 7% increase in deaths after common surgery (Aiken et al., 2014);
- Every 10% increase in bachelor-educated nurses is associated with a 7% lower mortality (Aiken et al., 2014);
- 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% (Tubbs-Cooley, et al., 2013).

Nurse/midwife-to-patient ratios will contribute to organisational productivity, hospital efficiency and continuity of patient care by increasing staff satisfaction, decreasing attrition rates, reducing service variation and improving equality across the healthcare sectors.

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 (Twigg et al., 2013).

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 (Jackson, et al., 2011). Improved nurse staffing and skill mix levels will reduces these types of adverse events and minimise unnecessary costs (Aiken et al., 2014; Lankshear et al., 2005; Twigg et al., 2013).

In honouring its pre-election promise, the Queensland Government (2015) announced in the 2015-16 budget it had committed:

- $110.7 million over four years, in addition to internal funding, to offer up to 4,000 additional places to new Queensland nurse and midwifery graduates and 16 new nurse educator positions in Queensland Hospital and Health Services;
- $101.6 million over four years, in addition to internal funding, to employ 400 experienced nurses to help patients navigate the health system;
- $11.4 million over four years to restore a school aged nurse service in the Logan area and surrounding suburbs and to expand this service to other vulnerable Queensland communities;
- to introduce legislation for minimum nurse/patient ratios in the public sector from 1 July, 2016.

These are significant changes for nursing and midwifery in Queensland. In delivering on its promise to implement nurse/patient ratios, the 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.

For health services, this means the delivery of direct patient care based on sound staffing methodologies is more achievable and affordable.

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