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To whom it may concern,

Re: Feedback on IHPA Work Plan 2020-21 Draft

The Australian College of Nursing (ACN) welcomes the opportunity to provide feedback on the Independent Hospital Pricing Authority (IHPA) Work Plan 2020-21 Draft. ACN has consulted its wide membership to formulate a response to IHPA's consultation questions. ACN is supportive of the Strategic Objectives and Deliverables within the Work Plan 2020-21 Draft. Below are some specific comments:

Strategic Objective One – Perform IHPA Pricing Functions

Page 9 (a) Development of the Pricing Framework for Australian Public Hospital Services 2021–22

ACN believes working on the Pricing Framework is one of the main ways to achieve quality care delivery for patients and safety and support for nurses. ACN has previously provided feedback to IHPA on their Consultation Paper on the Pricing Framework for the Australian Public Hospital Services 2020-21. ACN strongly supports easy access and equity in health care services for patients. All pricing models should be considering what service provider or individuals can provide services (such as clinical capacity, legislative framework) rather than which providers have traditionally provided services. The differences in costs (both actual and opportunity) plus the equitable distribution of opportunity may lead to efficiency gains alongside the competitive effect which may enhance service delivery. This is with the understanding that competition does not always equate to improved services.

ACN supports moving the health funding system towards a patient-centered, outcomes-focused and value-based care system. Essential elements of these principals are the coordination of care across health care settings (integrated care), open access to patient data (both service and outcomes related) being both compatible and portable between health care providers and a move away from episodic volume-based healthcare. ACN believes in easy access and equity in care for patients and supports nurses to work to the full scope of their practice at the frontline of care delivery. Australia's public hospitals need to be efficiently and accurately funded to achieve these goals.

ACN members are supportive of IHPA's efforts towards the Pricing Framework and looks forward to the release of the final Pricing Framework which has been edited according to public consultation feedback.

Page 10 (c) National Efficient Price (NEP) and National Efficient Cost (NEC)

Activity-based funding (ABF) and block funding have certain limitations which need to be taken into account. There needs to be more clarity around where ABF is practicable and around its limitations. ACN strongly supports value-based health care and bundled payments funding models. Current Activity Based Funding models designed by IHPA do not provide incentives to maximise efficiency. ACN believes a focus on health care delivery should be on providing high value care to patients, with a patient-outcomes focused, value-based model of funding.

Further, unavoidable variations in cost must take into account the increasing medical gaps in rural and remote settings (GP absences) that result in transfer of care activities or follow up to regional facilities.

Page 11 (e) Pricing and Funding Safety and Quality in The Delivery of Public Hospital Services

ACN is supportive of the development of a software tool to track avoidable hospital readmissions. This data can help increase awareness and decrease reoccurrence of these avoidable costs and complications.

Furthermore, funding should consider upstream elements (such as causation) of Hospital Acquired Complications not just dealing with occurrences or their consequences. Funding for this aspect should take into account measures to incentivise the use of evidence based or evidence informed practice which is a proven effective strategy to reduce error or complications but comes at a cost for either purchase or dissemination and staff training.

Page 12 (h) Price Harmonisation Across Care Settings

ACN members are strongly supports price harmonisation across care settings as it allows for coordination of care across various health settings and removal of barriers and challenges as you move from one area of care to another. This allows for outcomes-based care for patients and efficient costing, as it ensures that there is no financial incentive for hospitals to admit patients previously treated on a non-admitted basis due to a higher price for the same service.

Hospital services provided in community, have a funding barrier with current Tier 2 due to inefficiency of travelling between patients, e.g. palliative care. Price harmonisation to reflect less volume and geographical challenges will support sustainability of these services.

It appears consistent with principles of equity that funding for services of same day services versus admitted / non-admitted services are case-based to account for circumstances such as patients from remote or rural locations.

Strategic Objective Two – Refine and Develop Hospital Activity Classification Systems

Page 15 (a) Acute Care Classifications

Nurse-led consulting services for inpatient activity, such as wound Nurse Practitioner (NP), are not supported in the current classification which only acknowledges medical consultant for inpatient, and NP for outpatient.

Page 16 (d) Tier 2 Non-Admitted Services Classification

Funding should take into account providers who could provide the service rather than funding those who have traditionally provided the service, as this may be a driver for organisations to evolve their workforce and develop alternate providers e.g. Physiotherapists, nurse practitioners etc. which have evidence of increased availability and potentially reduced cost base per provision of care. Further non-admitted services to be considered:

- Access for 10 series procedures for nurse practitioners will increase sustainability of service models
- Firming up of MDT 20 series will enable recognition of this activity and contribute to sustainability (as not all states have adopted MDT as a 20 services)
- Firming up home telehealth (virtual health) consultations under 20 series, to align with in-person price weighting per specialty, will enhance innovative clinical models' sustainability.

Page 16 (e) Australian Non-Admitted Care Classification

Funding should be flexible enough to enable service provision to seamlessly transition to non-admitted care initiatives, without the organisation being penalised for the same service transition even though this is in the patients' best interests.

Page 17 (f) Australian Emergency Care Classification

Only with access to consistent and certain data can truly informed decisions be made on actuals. Support for this element is strong however refinement of classifications will need to be conducted to capture accurate information.

Page 18 (g). Australian Teaching and Training Classification

All professional groups must be considered in relation to the classification to ensure a sustainable, highly capable and skilled workforce, rather than just a focus on one health professional group e.g. medical practitioners. There are public hospitals that are described as teaching hospitals however

the teaching is focused on clinical placements for undergraduates of all craft groups and then almost exclusively the pathway for medical teaching through the continuum of intern to specialist. (Protected teaching time, directors of education etc.)

Teaching for other craft groups is often limited to functional teaching on tasks to complete roles (CPR, wound care, use of computer-based systems etc.) rather than transformational teaching for managers to manage and craft groups to evolve such as nurses to nurse practitioners or managers to highly effective mid-level managers. If we do not focus on incentivising the creation of these types of roles and to develop appropriate skill sets for individuals to manage their business from a financial and data centric perspective, opportunities for whole-of-system improvement and reform will be missed. Unless considerable funding is specifically availed to support these types of roles then traditional practices will perpetuate, data will remain poor and subsequent decisions will continue to be based on inadequate frontline understanding of elements of the health business. Such circumstances (anecdotally) lead to poor data, financially incompetent (albeit well intended) managers, huge inefficiencies in service delivery and negative influence on key decision makers, resulting in a continuation of traditional practices despite better alternatives being an option.

Transitioning to alternative models of funding in such growing and developing workforce may be just the driver for the change required.

Strategic Objective Three – Refine and Improve Hospital Costing

Page 21 (a) Australian Hospital Patient Costing Standards

With a number of changes in nursing roles occurring across Australia, the teaching and training aspect must also consider nursing to ensure a sustainable, flexible and adaptable health workforce.

Page 21 (b) Collection of NHCDC for public and private hospitals

ACN members are supportive of the collection of National Hospital Cost Data Collection (NHCDC) and its analysis. However, this data and analysis should be accessible for key stakeholders.

Page 22 (d) Costing Private Patients in Public Hospitals

This is supported so long as the public hospitals are not disadvantaged financially as a potential unintended consequence.

Strategic Objective Four – Determine Data Requirements and Collect Data

Page 25 (a) Revision of the Three-Year Data Plan

ACN believes a revision of the three-year data plan will provide further clarity on data standards which should influence better data for use.

Page 25 (b) Phasing Out Aggregate Non-Admitted Data Reporting

ACN supports this vital aspect as it is likely to allow an understanding of actual costs rather than deal with the limitations created through aggregation.

Page 26 (d) Individual Healthcare Identifier (IHI)

ACN members are strongly supportive of the inclusion of the IHI in national data health sets. There will be some privacy concerns and issues to be dealt with, however this data is very useful as it allows for linked patient data, allowing hospitals to review care pathways and develop value-based healthcare proposals.

The benefits of this aspect are potentially huge. To be able to journey specific patients across health journeys accurately could create very beneficial opportunities for new efficiencies as well as provide opportunities to question current practice. It could also provide patient level activity understanding allowing the ability to allocate more appropriate workforce options tailored to actual patient interactions rather than carrying on in a traditional paradigm that may not be the best use of financial capacity.

Page 26 (e) Improvements to Data Submission, Loading and Validation Processes

ACN believes this is a good strategy, as less barriers for data submission should ultimately lead to better quality and more timely data.

Page 28 (g) Data Compliance

The requirement for a statement of assurance is supported and will strengthen the focus and understanding of the need for data compliance. The signature should be the highest level of responsibility within the health service – e.g. Director-General, CEO or Board Chair

Page 28 (h) Promoting Access to Public Hospital data

ACN members are strongly supportive of this and believes this resource should be available as soon as possible. Open access to data is of high importance to the future of health care. Currently many projects are being undertaken to gather different aspects of a patients' data as well as data from various health settings and health professionals. This will allow transparency, aid in data analysis, inform policy decisions, and enable better integrated health care as well as accurate and efficient delivery of funds. Both, accessible data and integrated care, support a value-based health care system where the focus is on patient outcomes, instead of volume fixed price healthcare.

Improved access to accurate data and appropriate benchmarking is a particularly important aspect of having conversations at the operational level focusing on efficiencies, transparency and appropriate clinical behaviours by all providers.

Strategic Objective Five – Resolve Disputes on Cost-Shifting and Cross-Border Issues

ACN members are supportive of the IHPA's role to investigate and make recommendations concerning cross-border disputes and to make assessments of cost-shifting disputes. Cost shifting considerations needs to be vigilant in changes to remuneration strategies as one of the elements of change. A clinical model which is provider-incentivised to increase activities may lead to different cost burden than a model where the clinician is salaried for service delivery remembering that more expensive/extensive care does not automatically equate with better quality care, but the higher cost care reduces overall capacity to provide greater numbers of care due to its financial impost on the system.

Strategic Objective Six – Independent and Transparent Decision-Making and Engagement with Stakeholders

Page 33 (a) Monitor and Evaluate the Introduction of ABF

It is vital that funding should be flexible enough to support best practice initiatives that are often community-based. Any movement of community services back into public hospitals needs thorough investigation to ascertain factors affecting these decisions. Funding should not prevent best practice community initiatives, focusing on finances rather than the needs of the community and individual patients.

However, there seems to be a considerable number of practices (anecdotally) which do not meet the ethical, transparent or cost-effective standards that are being striven for. Thus, in certain situations monitoring and evaluation are supported down to this level. A stick and carrot approach may be needed for the truth with this element to be fully uncovered. The transfer of subsequent publicly funded follow-ups for privately or community funded initial treatment is one such example.

Page 34 (b) Evidence-based ABF related research

ACN is strongly support of the value-based healthcare funding model, preferring its focus on patient outcomes and experiences. ACN calls for a move away from bundled payments and ABF towards a more value-based model.

Page 34 (c) Support ABF Education at a National Level

ABF education may benefit healthcare innovation by being availed to a slightly larger pool of individuals outside of government services, major private providers or the tertiary sector. The extended private sector may provide some new questions that drive improvements or new ways of working towards existing challenges.

However, as a move towards a more value-based health care funding system is inevitable in the future, there should be research, education and support in this area.

ACN is the national leader of the nursing profession and a community of dynamic and passionate nurses. We are committed to our intent of advancing nurse leadership to enhance the health care of all Australians. Our membership, events and higher education services allow nurses at all levels to stay informed, connected and inspired. We are excited to lead change and create a strong, collective voice for our profession by bringing together thousands of extraordinary nurses from across the country. By doing this, we build a strong collective voice for nursing and command the respect and recognition our profession deserves.

If you have further enquiries regarding this matter, please contact me, Dr Carolyn Stapleton FACN, Executive Director – Policy and Advocacy, at Carolyn.Stapleton@acn.edu.au.

Yours sincerely

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