Australian College of Nursing

Value-Based Health Care through Nursing Leadership

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EXECUTIVE SUMMARY

This White Paper outlines how Australian, State and Territory governments can enable nursing services to address issues which impact on access, equity and the financial sustainability of the health and aged care systems in Australia. To achieve this, ACN recommends complementing traditional health funding models with new outcome-based funding models and other variants including access to Medicare item numbers for nurses. New funding approaches are being implemented effectively in European countries and in the United States; and are now being trialed in a variety of settings across Australia.

Australia has a world-class health system that offers a high standard of nursing, medical and allied health services. However, there are inequities within the health care system that impact on the aged, those with multiple, chronic diseases and those who are marginalised and disadvantaged by geography, culture or poverty. Delayed or inadequate care for these population groups over time can cause deteriorating health, leading to increased pressure on the public health system.

Health is one of the largest and fastest growing sectors of the economy, accounting for an increasing share of Gross Domestic Product (GDP)[1]. It is also one of the largest and fastest growing fiscal pressures facing the Australian Government. An ageing population, development of new and often more expensive technologies, and the growing public expectation of a better health system will require further public investments in health[2]. According to the Productivity Commission (2017)[3] there are opportunities to improve health outcomes for given expenditure or to achieve existing health outcomes for less, including more effective prevention. Many of these opportunities relate to issues regarding how the health system is organised and funded, the behaviours of clinicians, administrators, bureaucrats and the people they serve.

Doing better with our health resources requires health and economic reform that puts patients at the centre of the health care system. This paper highlights the benefits of value-based health care (VBHC), what it means for consumers, how it is categorically reliant on nurses and team-based care models, and how adoption of new innovative nurse-led models of care have the potential to positively impact all Australians and ensure the sustainability of Australia's health and aged care systems into the future. The value of nursing services cannot be understated in achieving VBHC in Australia.

It is timely that the Australian Government embraces new models of care to meet the challenges presented by Australia's evolving health care requirements and to make the health system work cost effectively in years to come. Basic funding increases without reforms will not ensure the sustainability of Australia's health and aged care systems[4]. This has been evident through the Royal Commission into Aged Care Quality and Safety, identifying a system failing to meet the needs of older, vulnerable, citizens[5]. ACN argues there is a need to shift the whole system towards models that target core issues in our health and aged care settings. ACN strongly believes the **right incentives** need to be in place to provide the **right care** at the **right time** for the **right price**, in the **right place** by the **right provider**, as adapted from the Australian Commission on Safety and Quality in Health Care (ACSQHC) definition for patient quality and safety[6].

To address these issues, the VBHC Working Group, comprising Australian nurses with expert knowledge in health care delivery models, was established by ACN in 2019. The VBHC Working Group reviewed international and national literature around the defining principles of VBHC, and the implementation of VBHC with measurable outcomes across a range of health care settings, departments and disciplines and the centrality of nursing to VBHC's authentic and effective functioning.

DEFINITIONS

Gross domestic product (GDP)
Total market value of goods and services produced in Australia within a given period after deducting the cost of goods and services used in the process of production but before deducting allowances for the consumption of fixed capital. Thus, GDP as defined here is 'at market prices'. It is equivalent to gross national expenditure plus exports of goods and services less imports of goods and services[7].

High-value care
High-value care is clinically relevant and provides individualised benefit to a patient at the lowest practicable cost[8].

Low-value care
Low-value care refers to the use of an intervention where evidence suggests it confers no or very little benefit to patients, or the risk of harm exceeds likely benefit, or more broadly, the added costs of the intervention does not provide proportional added benefits[9].

Patient-reported experience measures (PREMs)
PREMs are used to obtain patients' views and observations on aspects of health care services they have received. This includes their views on the accessibility and physical environment of services and aspects of the patient-clinician interaction[10].

Patient-reported measures (PRMs)
PRMs collect information about the patient experience and the outcomes of health service interventions, from the patient perspective[11]. PRMs can be used to measure health performance – for both national and local area monitoring – and to inform ongoing improvements in the quality of health services[12].

Patient-reported outcome measures (PROMs)
The US Food and Drug Administration's (FDA) definition of a patient-reported outcome is "any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else"[13].

Value-based health care
The Australian Centre for Value-Based Health Care defines value as "health outcomes that matter to patients relative to the resources or costs required, over a full cycle of care"[14].

Primary care
The phrase primary care is used to mean the care context, the first level of contact for most patients and where general practitioners work.

Primary health care
Primary health care has a much broader meaning, requiring interdisciplinary teamwork, encompassing the community and considering broad determinants of health such as housing and educational levels[15].

INTRODUCTION

Australia's health care system is amongst the best in the world, with an overall ranking of second when compared to other countries in the Organisation for Economic Co-operation and Development (OECD). It ranks highest on administrative efficiency and health care outcomes and is among the top-ranked countries on care process. However, out of 11 countries its ranking drops to seventh for equity and fourth for access[16], suggesting access and equity are areas of opportunity when considering health and economic reform of the health care system in Australia.

The World Health Organization's (WHO) classic definition of "health" as contained in the Alma-Ata Declaration of 1978 is as follows: health "*is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*"[17]. The WHO Declaration further states that achieving a high standard of health is a "*fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal*"[18]. ACN adopts this definition as well as endorsing WHO's principle that "*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*"[19]. A major aim of any health system is to prevent disease and other ill health and injury, and to maintain health – not just treat illness – so that people remain as healthy as possible for as long as possible[20].

In the international context, the life expectancy of Australians is among the highest of people living in developed countries[21]. At the same time, illness, disability and reduced life expectancy are unevenly distributed across the population. Inequity in our system impacts the elderly, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) populations, those with chronic illnesses, disabilities, mental illness or people living in rural and remote locations[22].

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. Behavioural risk factors are those that individuals have the most ability to modify[23]. Through reducing exposure to modifiable risk factors such as tobacco smoking, being overweight or obese, high alcohol use, physical inactivity and high blood pressure, Australians can prevent many of the health problems affecting the population. Many of the key drivers of health and welfare are in our everyday living and working conditions with social determinants, such as income, education and employment, strengthening or weakening the health and welfare of individuals and communities[24]. These risk factors and social determinants need to be considered when developing strategies to improve access and equity to health care.

Health systems are also experiencing growing pressure from an ageing population. Nationally, rates of chronic conditions and their associated risk factors are increasing. At an individual level, Australians diagnosed with one or more chronic conditions often have complex health needs, die prematurely and have poorer overall quality of life[25]. Beyond the population impact, chronic conditions have a major impact on the individual and their social and support networks in terms of disability, productivity and lower labour force participation[26]. Chronic diseases and the use of new technologies for early detection, diagnosis and management of chronic diseases account for the largest and fastest growing sectors of the economy, and an increased share of GDP. Chronic disease is also one of the largest and fastest growing fiscal pressures facing government which drives debate on the sustainability of the health system into the future. The current and projected demands on Australia's health care system cannot be understated. Harvard economist Michael Porter emphasises that today's care delivery approaches reflect legacy organisational structures, management practices, and payment models based on historical medical science and delivery practices[27]. This paper argues that health service delivery needs to evolve, with current methods of promoting health and providing care being examined for their "value".

The case for providing health outcomes that matter to patients is compelling when driving reform of the health and aged care systems. It is here that nursing service provides a solution to cost-effective care that is consumer-driven and where outcomes are measured based on patient experiences and quality outcomes. Value-based health care (VBHC) is defined as "*the health outcomes that matter to patients relative to the resources or costs required*"[28]. VBHC is being trialled in Australia with the first major implementation in Victoria. Preliminary results show significant increases in preventive interventions and clinicians working to the top of their scope of practice, along with a reduction in low-value care and improved patient appointment attendance[29].

Nurses are most likely to be the first health professional seen by people in rural, remote and very remote communities both for specialist and primary care needs. Nursing is the largest, single health profession in Australia with the highest match to population across the country[30]. The impacts of nursing services along with access and cost-effective care will be explored in this White Paper. However, further data are needed on the long-term impacts of nurse interventions and potential savings to the health care system.

The economic productivity of Australia is dependent on the health of its citizens and nursing care is unequivocally linked to improving the health and wellbeing of our communities through their professional and social impacts. The public have regarded nursing as the 'most trusted profession' for many years[31] making nursing's contribution unique due to its scale and the range of roles nurses have in our communities. Nurses are a part of their local communities, sharing common cultures, strengths and vulnerabilities. Nurses have the ability to shape and provide effective interventions to meet the needs of patients, families and communities[32]. Enabling nursing services through a VBHC approach should be a key strategy for governments to achieve a sustainable health care system that ensures our communities enjoy the highest attainable standard of health. The VBHC approach encourages improved equity and access to health systems and promotes outcomes that matter to patients.

HEALTH FUNDING IN AUSTRALIA

Medicare is Australia's universal health insurance scheme which guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at a low or no cost. Medicare provides mechanisms for financing hospitals and doctors with limited support to other health professionals.

A complicated mix of public and private funding supports Australia's health services, with the main payer being the government through taxpayer revenues. Some services are the responsibility of the Commonwealth and others are managed by the states and territories[33]. The complex structure of Australia's health system is reflected in its funding arrangements with the Commonwealth, state and territory governments funding and delivering services across different care settings. Funding for health also comes from non-government organisations, private health insurers and individuals when they pay for some products and services without full, or with only partial, reimbursement. The three largest areas of expenditure in health are hospitals (41%), primary health care (23%) and pharmaceuticals (14%)[34].

Activity-based funding

The public hospital setting is funded by the Commonwealth, through state and territory governments using (where practicable) activity-based funding (ABF). ABF is a way of funding whereby hospitals are paid according to the number and mix of patients they treat. That is, the more patients treated or the more complicated the treatment for a patient, the more funding a hospital receives[35]. The Independent Hospital Pricing Authority (IHPA) states that:

> *"ABF funding should support timely access to quality health services, improve the value of the public investment in hospital care and ensure a sustainable and efficient network of public hospital services. Activity-based funding payments should be fair and equitable, including being based on the same price for the same service across public, private or not for profit providers of public hospital services"*[36].

According to the Productivity Commission's report, *Efficiency in Health* (2015), one of the advantages of ABF is that it provides a financial incentive for hospitals to reduce their costs and increase their activity. In other words, hospitals that provide a service at a cost lower than the price they receive for it, make a profit for that service and have an incentive to increase activity[37].

The fundamental concern with ABF within an integrated care framework is that its incentives only relate to hospital care (including hospital in the home programs). From an ABF perspective, hospitals generally benefit from illness not from its prevention or its management in lower cost settings[38] such as in the primary health care setting. This shift from episodic care in a hospital to the ongoing management of chronic conditions means current funding arrangements are limiting the coordination of patient care across care settings inside and outside hospitals[39,40].

Fee-for-service funding

Fee-for-Service (FFS) models of remuneration refer to payments for each individual patient service health care providers deliver. It is the dominant health care funding model for primary care in Australia[41]. In the primary health care (PHC) setting, FFS payments occur through the Medicare Benefits Scheme (MBS) which provides a payment for MBS item numbers. MBS item numbers are not accessible to nurses in general practice, other than a limited number of items for nurse practitioners, as nurses do not have provider numbers and therefore are unable to access MBS item numbers directly. In the PHC setting, nurses deliver services such as cervical screening, immunisations, wound care and treatment plans which are provided "for and on behalf of" a general practitioner (GP) with the MBS payment going to the GP or the practice.

The FFS funding model is an easy to manage and administer system that incentivises accessibility. It does not reward successful efforts to prevent chronic conditions or stop people from entering the hospital system[42] and has been suggested as a factor contributing to fragmentation of care[43] between health professionals and service providers. This is supported by the international experience which concludes that the FFS model rewards the overuse of services, duplication of services, use of costly specialised services and involvement of multiple physicians in the treatment of individual patients.

Block funding

Block funding is a periodic global lump sum payment independent of the number of patients treated[44]. Block funding grants are provided by the Commonwealth to the states and territories to fund particular services or activities, for example small rural hospitals, teaching, training and research, non-admitted mental health and other public health activities. The 2020 Workforce Incentive Payment (WIP) is a form of block funding; described by Services Australia as payment which "provides incentives to general practices who employ nurses"[45]. The WIP does not cover the full cost of employing an eligible health professional, therefore the costs of employing a nurse are offset through a combination of specific items of service such as MBS items paid to GPs for nursing interventions and efficiencies in patient care.

Access to quality primary and community care could be better

Among OECD countries, Australia has the highest share of health spending dedicated to primary care activities (18%)[46]. At the same time, the OECD has identified reducing obesity and strengthening primary care as the two top issues for Australia[47]. Primary care services are the main entry point into the health system. Primary health care keeps people well through health promotion and disease prevention services, manages long term conditions and treats the majority of uncomplicated cases[48]. Measures of primary care effectiveness suggest Australia could improve the management of asthma and chronic obstructive pulmonary disease[49] with timely and adequate PHC. The potentially preventable hospitalisations indicator is a proxy measure of primary care effectiveness as it measures hospital admissions that potentially could have been prevented by timely and adequate health care in the community[50]. Chronic and complex conditions are one of the four main causes of preventable hospitalisation[51]. In 2017-18 approximately 7% of all hospitalisations were classified as potentially preventable which equates to nearly 10% of all hospital bed days[52].

Access to PHC is important for the early detection and treatment of chronic disease risk factors and conditions and improved health outcomes. The principle objective of Medicare is to remove or reduce financial barriers to health care access for all Australian residents[53]. However, despite a universal health care system, 16.2% of the population reported skipping consultations due to cost[54]. This is much higher than the OECD average of 10.5%[55]. Out of pocket costs now amount to 2.5% of average annual income[56] with the Intergenerational Report projecting real health expenditure per person to more than double over the next forty years[57].

The FFS funding model significantly impacts on services that can be delivered by nurses in general practice[58]. Within the PHC setting, practice nurses provide health assessment, triage and referral, management, self-management support and education, health promotion and health system coordination of care[59,60]. Nurses working to their full scope of practice as part of an interdisciplinary team can enable more integrated, efficient and accessible health care[61]. Nurses undertaking these activities improve patient outcomes, enhance productivity and provide better value for money for health services provided[62,63]. Of concern, a national survey of practice nurses[64] found 39% of respondents reported not using their knowledge and skills fully. Nurses reported being held back by general practitioners and practice managers who would not approve requests to undertake more complex activities. These practices create inefficiencies in the PHC setting, limiting nurses' autonomy and restricting them from working to their full scope of practice. Ultimately, this impacts on care provided to people in our communities and their ability to enjoy the highest attainable standard of health. To achieve the full potential of PHC, we need to recognise the increasing roles of all health professionals in providing care as part of an interdisciplinary team-based approach that is safe, equitable, accessible and cost effective and meets the patients' needs.

Within Australia, access to appropriate ongoing community-based health care is limited with access to outpatient or ambulatory care services such as nurse-led cardiac clinics, obesity clinics, hospital-in-the-home, and other nurse-led ambulatory services restricted through the requirement for GP or medical specialist referral. Many rural and remote communities are dependent on nurse-led services, and in these communities, nurses are often the sole resident health practitioner available to a community[65]. Existing funding models and historical perspectives limit access to community and primary health care services (C&PHC), and the provision of genuine team-based care approaches that meet the care needs of individual patients.

The aspiration of national and international health systems is to provide integrated care to improve patient experiences and outcomes, but also to reduce avoidable ill health and costs[66]. This cannot be achieved with existing funding models such as FFS, ABF and a reliance on out-of-pocket costs which do not reward the prevention of hospitalisation or rehospitalisation, effective control of chronic conditions, or care coordination[67,68]. OECD reports on primary care in Australia highlight the right resource mix, training incentives and platforms for service delivery as key to improving primary care, especially for underserved populations. This includes wide adaptation of team-based care including doctors, nurses and community pharmacists[69].

Funding models act as a barrier to coordinated care that crosses the continuum of care

Australia's fragmented funding and governance systems discourage service provision that would provide the best outcomes for its expenditure. Current health care funding models encourage activity within the PHC system and hospital system but does not promote outcomes across the continuum of care. The budget silos between acute and PHC create a barrier to the delivery of team-based health care that ensures patient-centred continuity of care. Continuity of care reflects the extent to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences[70]. This conundrum will continue to put pressure on health expenditure in the Australian health care system as chronic diseases already account for approximately a third of hospitalisations, two-thirds of the total disease burden and a significant proportion of all deaths in Australia[71]. Chronic diseases are placing a high burden on individuals, their families and carers, and the health system.

Without good continuity of care and support, many patients, carers and families experience fragmented, poorly integrated care from multiple providers, often with suboptimal outcomes and risk of harm due to failures of communication, inadequate sharing of clinical information, poor reconciliation of medicines, duplication of investigations and avoidable hospital admissions or readmissions[72]. People who have chronic conditions, a complex medical history, or who take several medications require continuity of care[73,74] to optimise their wellbeing and avoid presentations to the acute care setting.

The importance of early detection and intervention along with the complexity of care requirements of a person with a chronic condition is illustrated in a hypothetical case outlined in Box 1.

Box 1

Mr. Smith has led a relatively sedate life and has a Body Mass Index (BMI) of 30 which puts him in the class 1 obese range. He has smoked for 30 years, has a history of hypertension (high blood pressure) and a family history of heart disease which are risk factors for chronic diseases such as coronary artery disease. At 51 years of age he was diagnosed with coronary artery disease and had an acute myocardial infarction (heart attack). Soon after he was diagnosed with a cardiomyopathy (enlarged heart), he suffered symptoms of heart failure (HF) and required ongoing management of his shortness of breath which is associated with fluid retention whereby fluid accumulates in the lungs, legs and abdomen. This can be life threatening if it is not treated in a timely manner.

Mr. Smith, now aged 56, lives with his wife who is struggling to care for him at home. He frequently presents to the emergency department (ED) and is hospitalised for symptom management control. During his last admission to hospital he was advised there is little more that can be done to manage his condition and he would require palliative care services for ongoing symptom management. He has expressed a wish to die at home with his family.

*this is a fictious case and is not based on a specific person

Mr Smith's story is a common scenario with cardiovascular conditions being the leading cause of death in Australia and responsible for 13% of hospitalisations[75]. Prior to his diagnosis, Mr Smith was considered at high risk of heart disease, therefore requiring education and ongoing management in the PHC setting to support him to cease smoking, reduce his weight and exercise regularly. These are key target areas in PHC for preventive care, however most people who meet these criteria have not discussed preventive health care with their GP[76].

Following his heart attack, Mr Smith and his wife required education about his risk factors and his chronic disease including support to enable him to self-manage his shortness of breath symptoms at home. This education and support should commence in the acute care setting following diagnosis with ongoing revision and management of his treatment plan in the PHC setting. Several evidenced-based non-pharmacological strategies improve outcomes for patients with HF, including multidisciplinary disease management, nurse-led medication titration and exercise training[77]. This requires continuity of care across the health care settings between the acute and PHC providers. It is essential for management to aim at symptom relief and slowing disease progression which has been demonstrated to reduce exacerbations, decrease hospitalisations and prolong survival[78].

Mr Smith is nearing end of life and requires a referral to palliative care services. Surveys consistently show that 60-70% of people would prefer to die at home[79]. Mr Smith has a 14% chance of achieving this in Australia[80]. Paradoxically, the likelihood and timing of death is more predictable and there is time to prepare because people are now much more likely to die from chronic disease in old age[81]. Dying in Australia is more institutionalised than in most countries with medical and community attitudes plus a lack of funding for formal, home-based care means Australians die at home at half the rate than for people in New Zealand, the United States, Ireland and France[82].

The diverse range of needs for people with life limiting illness means health professionals working in a range of settings, from various disciplinary backgrounds, will have a role in the provision of palliative care. Palliative care services have been shown to alleviate end stage symptoms, improve quality of life and reduce rehospitalisation[83] with nurse-led models of care demonstrating improved symptom outcomes, psychological wellbeing, end of life care planning, and care coordination[84]. Reform of palliative care services is required to address the issues related to the existing funding models and limitations to the scope of practice of nurses.

The current funding models drive a supply centric health care system which impacts on access to quality primary and community care while acting as a barrier to coordinated care across the continuum of care. The nursing practice model is and has long been patient-centred and based on collaborative and respectful partnerships. ACN has consistently highlighted the potential of advanced practice nurses[85] and the role of nurses in chronic disease prevention and management, particularly in rural and remote areas[86] and in the provision of palliative care[87]. Health system reform must go further than minor changes to funding models to enable nursing services to address issues of access and equity while ensuring the financial sustainability of the health and aged care systems. Alternative funding models are being trialled in Australia and aim to provide financial flexibility that encourages improved models of care or greater standardisation of evidence-based care while delivering outcomes that matter to patients.

ALTERNATIVE FUNDING MODEL

"There is a need to create better structures and new incentives that promote efficient prevention and management of chronic illness throughout the health system"[88]

Health care worldwide is changing with the rapid development of artificial intelligence, adjunctive technologies and evidenced-based care combined with the needs and expectations of consumers to be at the centre of their care. This along with the growing burden of chronic illness, its prevention and management will increasingly put pressure on the health care system and fiscal pressure on governments in Australia. This paper has revealed the limitations of current funding models in Australia; exposed the restrictions placed on nursing services; and emphasised the prevailing barriers to authentic team-based care. ACN argues for models of care that provide the **right incentives** and the **right care** at the **right time** for the **right price**, in the **right place** by the **right provider**[89]. This whole of system reform is categorically reliant on enabling nursing services to address issues of access, equity and ensure the financial sustainability of Australia's health care system.

Devised by Harvard economist Michael Porter, VBHC is a framework that focuses on what patients value in terms of their health and allocates resources according to the health outcomes provided by the system[90]. While the rationale for implementing VBHC is clear, it requires a paradigm shift from a supply driven model to a more patient-centred system of care[91]. This call has been echoed in Australia, with the Productivity Commission and health organisations repeatedly identifying both the health[92] and economic outcomes of reforms that place the patient at the centre of the health system[93,94,95,96].

Value-based health care is an alternative funding model

VBHC is the "health outcomes that matter to patients relative to the resources or costs required"[97]. The health outcomes that matter to patients are multidimensional, including factors much broader than traditional clinical indicators. The resources or costs required must reflect the actual costs of the care provided to a patient over a full cycle of care recognising that a patient's full course of care requires an interdisciplinary team-based approach over time. The value-based approach to health care enables a patient-centric way to design and manage health systems[98].

VBHC therefore is not to be viewed in the context of a hospital, care location, specialty or intervention. Rather, value is viewed as being created at the local level of the patient, specifically their conditions over the full cycle of care across the health sector[99].

VBHC requires:

1. Systematically agreeing on and measuring outcomes that matter to patients, and costs required to deliver those outcomes over a full cycle of care.
2. Tracking those outcomes and costs for defined populations on an ongoing basis.
3. Developing customised interventions to improve value for each population[100].

VBHC can therefore be understood as a simple equation[101].

$$\text{Value} = \frac{\text{The set of outcomes that matter for the condition}}{\text{The total costs of delivering these outcomes over the full care cycle}}$$

VBHC is different from care with traditional funding models, on both the outcome and cost sides of this value equation. Traditionally, outcome measures have focused on health care provider behaviour and overall patient success. Measures for VBHC are different in that outcomes are:

- measured by condition(s) of the patient not by specialty and intervention;
- multi-dimensional in that they focus on what matters to the patient and not just the health care provider;
- inclusive of patient reported outcomes; and
- focused on the full cycle of care[102].

The premise of VBHC also incentivises efficiency in the cost of delivering outcomes across the full cycle of care, unlike FFS and ABF which financially incentivise service volume rather than patient outcomes. VBHC also differs from bundled payment models which can dis-incentivise providing additional care (often focused at highly beneficial preventive health or greater care coordination) that are not defined 'activities' included in a funding bundle. VBHC presents a 'whole-of-system' paradigm that incentivises all practitioners within the system to deliver the outcomes that matter to patients in the most efficient manner.

"The current system encourages activity not outcomes"[103]

Benefits of a value-based health care approach

There is a strong motivation to explore the gains that VBHC can deliver. As previously mentioned, health accounts for a large proportion of GDP and will continue to place growing fiscal pressures on government. The ageing of the population is placing further structural pressure on Commonwealth, state and territory budgets as baby boomers retire from the workforce and their demand for health care increases.

With health expenditure continuing to grow and looming fiscal pressures mounting, there is a requirement to focus on ways to reform the health care system: improving standards of care while ensuring that funding is sustainable. The Productivity Commission has estimated that reforms to our health system, many of which address issues that a patient-centric system would overcome, could save $140 billion over 20 years.

"There needs to be acceptance by all actors in the health care sector that patients are the centre of the system in the same way disability care has shifted"[104]

While a suite of reforms is required to meet these challenges and to realise these savings, VBHC through its patient-centric approach presents a significant opportunity to align incentives in a way that both improves patient outcomes while decreasing the long-term costs of care. The principles of VBHC are flexible enough to be tailored and adopted in many different areas of the health system. For this reason alone, the potential for VBHC to deliver significantly improved health, wellbeing, fiscal and economic outcomes warrant investigation by all levels of government.

Measuring value

The ACSQHC (2019) states: "Patient-reported outcome measures support person centred and value-based care by providing a way of measuring health outcomes from the patient's perspective"[105]

The ACSQHC states that patient safety and quality is often summarised as the right care, in the right place, at the right time and cost. Further, ACSQHC defines patient safety as "*prevention of error and adverse effects associated with health care*" defining "quality" as "*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*"[106].

Internationally, the OECD is leading work on patient-reported indicators which will establish indicators that measure the outcomes and experiences of health care that matter most to people[107]. The ACSQHC is actively involved in this work which will enable international benchmarks for patient-reported indicators of health system performance from a patient's viewpoint. Health care is enhanced when patients share what is important to them and health services understand health outcomes from a patient's perspective[108]. The use of patient-reported outcome measures (PROMs) provides a structured way of helping patients to report information about health outcomes and drive quality improvement in a way that brings patients' voices to the fore[109].

Patient-reported outcome measures enable patients to report on their quality of life, daily functioning, symptoms, and other aspects of their health and wellbeing. Responses to PROM questions help hospitals and health care services provide the care patients need and want. These measures aim to fill a vital gap in our knowledge about outcomes that matter to patients[110]. There are two tools that reflect the early stages and approaches being undertaken to implement VBHC in Australia. These are 'patient-reported measures' (PRMs) and 'patient-reported experience measures' (PREMs).

Patient-reported measures collect information about the patient experience and the outcomes of health service interventions. This information can be used to measure health performance – for both national and local area monitoring – and to inform ongoing improvements in the quality of health services[111]. PRMs are now included in the Australian Health Performance Framework (AHPF) with potential to measure and inform assessments relating to the appropriateness and safety of care[112].

Patient-reported experience measures are used to obtain patients' views and observations on aspects of health care services they have received. This includes their views on the accessibility and physical environment of services and aspects of the patient-clinician interaction[113].

Patient-reported outcome measures demonstrate the significant interprofessional value of nursing services in enhancing patient outcomes and patients' experiences. This is because the experience of patients who interface with acute health care is, in many instances, heavily weighted towards nursing care. Nurses are integral to PRMs and PREMs because they consider "*the care and health-related services (physical, preventive, therapeutic, economic, emotional, and spiritual) as well as the needs, wants and expectations of the person, their family and significant others*"[114]. These qualities are the core components of PRMs and PREMs.

"Data and measurement— allowing for the ability to conduct cost-benefit analyses and to tap into patient outcomes data— are critical to successful adoption of VBHC"

In addition to patient-reported indicators, the availability of a national minimum dataset for nursing would benefit health services at the local, state and national levels; and undisputedly translate into improved patient care, and enhanced outcomes for patients. ACN has outlined a preliminary list of minimum dataset data elements to inform a national dataset[115].

Principles to guide reform

The proposed changes to the Australian health care system have the potential to offer very substantial gains to health, wellbeing and fiscal outcomes. While there is clear appeal in rapidly adopting a new approach to health care funding, implementation risks must be carefully considered to ensure potential gains are not wasted, and Australia's current system is not jeopardised. The current Australian health care system is complicated, with many interrelated components, layers of governance and funding sources. These all need to be carefully considered and accommodated as the VBHC initiatives are increasingly adopted throughout the system.

The Productivity Commission[116] outlines a set of principles for health care payment models, which have been sourced from the academic literature, to guide a reform process in Australia. These principles could guide the adoption of VBHC in Australia.

Figure 1 - Principles to guide the adoption of VBHC

Sourced and adapted from principles outlined in the Productivity Commission Report (2015) [117]

In Australia, VBHC is gaining increasing attention with various initiatives based on this concept underway or established. An assessment of the enabling environment in Australia[118], combined with the principles to guide the broader adoption of VBHC, form a useful set of tools for policy makers.

ACN advocates for a considered reform process that builds on the success of trials and programs already in place in states and territories. The recommendations accompanying this White Paper are aimed at progressing the core principles required to implement successful health funding reform and ensure policymakers recognise the value of nursing to deliver this reform and meaningfully incorporate this in any future policy.

"While outcomes measurement, patient-focused care practices and outcomes-based payment systems are all important in underpinning alignment with VBHC, countries also need an ecosystem of institutional and policy structures that support value-based approaches. Stakeholder buy-in is also key—from providers, payers, and patients"[119]

"Successful adoption of the components of VBHC also requires countries to have institutions that can set and review guidelines, examine the medical, social, economic and ethical impact of health interventions… and provide funding for research that addresses health-related knowledge gaps"[120]

PROVIDING VALUE TO PATIENTS

The value of nursing to deliver gains under a VBHC model cannot be understated. The dual imperative of providing outcomes that matter to patients at an efficient price will be achieved with a paradigm shift to a patient-centric approach to health care provision, ensuring the right resource mix and models of care to meet the needs of our communities, especially underserviced populations. This requires wide adaptation of team-based care and optimisation of nursing services.

This White Paper has demonstrated that current funding models impact on nursing's ability to work to its full potential which ultimately impacts on the care provided to people in our communities and their ability to enjoy the highest attainable standard of health. More equitable access to PHC services can undoubtedly contribute to reductions in the rates of preventable diseases, avoidable hospitalisations and lowering of mortality rates[121].

Nursing is highly regarded and has been ranked by the public as the 'most trusted profession' for many years[122]. Nursing is the largest, single health profession in Australia with the highest match to population across the country, including rural and remote areas. Nurses are most likely to be the first health professional seen by people in rural and remote communities for both specialist and primary care needs. The high levels of trust and professionalism nurses engender, coupled with their broad geographic scope, means nurses play a critical role in maximising patient outcomes and experiences.

Registered nurses (RNs) are regulated health care professionals, who provide holistic patient centred care in collaboration with other health professionals and individuals requiring care. Nurses are accountable and responsible for their own practice with legislation and regulation guiding the scope of that practice. Nursing's regulatory body is the Nursing and Midwifery Board of Australia (NMBA), whose role is to protect the public. RNs do not require supervision by other health professionals. Furthermore, it is neither appropriate or valid for nurses to provide care "for and on behalf of" any other health care professional.

The nursing model of practice has a unique care profile as nursing is both a service and an intervention[123]. A distinguishing characteristic of the nursing model is the nature of the relationship that nurses develop with individuals and communities. Central to the nursing model of practice is the triad of interrelated practice activities that comprises:

- interpersonal engagement;
- education for health and health maintenance; and
- coaching for self-care and carer-care competency development[124].

For some groups, this practice triad collectively enables and supports the person to remain in their community, manage self-care requirements and be experts in their own health issues. For those groups that require institutional care, this nursing practice model supports ageing in place and timely care to prevent avoidable hospitalisations. This is the nature of nursing practice that is consistently reported by the general public as "trust" that is most worthy of their regard and is the basis of unique and effective nurse patient interactions[125].

The value of nursing care cannot be understated

Australia's large, cost-effective and highly skilled nursing workforce is underutilised. At the same time, there are numerous examples where existing nurse-led initiatives (Appendix 1) demonstrate the potential of nursing service to provide real value to our most vulnerable communities. Unfortunately, these services are limited and are not accessible to most Australians.

Recognising the full potential of nursing service will provide the required care to consumer groups that currently experience inequities in our health care system. The nurse-led initiatives in Appendix 1 are examples of how nurses provide outcomes that matter to people impacted by older age, chronic disease, or those that are marginalised and disadvantaged by geography, culture or poverty. These initiatives are critical in that they:

1. Demonstrate promising success in terms of both patient outcomes, experiences and cost savings.
2. Provide the foundations for an evidence base and library of best practice to inform future program design, delivery and evaluation.
3. Demonstrate the wide applicability of VBHC initiatives, encompassing a broad spectrum of patient needs which have been met in a coordinated and integrated manner by different parts of the current system.
4. Engage clinicians and administrators in innovative programs which begin with the patient and break down traditional institutional, bureaucratic and funding barriers. The experience of these individuals, and the lessons learnt through these programs, are valuable when considering larger institutional and systematic reform.

The evidence of the impact of nursing on access to care, quality of care and health outcomes supports at least comparable, and in several cases, better patient outcomes when compared to medical led care[126]. Among other examples, an emerging body of evidence supports the role of nurses in prevention and management of chronic disease[127] and the benefits of nurse-led models/interventions for patients, services and health systems in caring for people with life limiting conditions[128]. These early projects and case studies highlight the key role nurses play in providing VBHC in the Australian context.

CONCLUSION

Australia's long-term national health plan (2019)[129] aims to make Australia's health system the world's number one. This plan will be achieved by preventing disease and promoting health, asserting more focus on patients' multidisciplinary needs, more affordable, and more accessible to all irrespective of where they live or who they are[130]. The current and projected challenges facing Australia's health and aged care systems necessitates reforms to existing and traditional models of care.

The existing funding models and regulation in Australia are limiting the role of nurses in providing outcomes that matter to patients. This is in a context where equity and access to care is limited for some consumer groups and where health care costs are increasing. The very nature of the nursing practice model places the patient at the centre of their care, enabling and supporting them to remain in their communities, manage self-care requirements and be experts in their own health issues. Nursing services must be enabled to work as an equal partner in a collaborative team, across multiple settings and complex structures in the health and aged care systems.

VBHC approaches currently being trialled at the local, state and national level, provide effective solutions to managing an ageing population, those with chronic/complex diseases and escalating health care costs for both the consumer and health care system as a whole. The highly educated nature of the nursing profession, along with its geographical scope and trusted community rapport, means front line nurses are central and well positioned to affect an advocacy role in health care system reforms.

Nursing is the solution to many of the problems plaguing our health and aged care systems and, as demonstrated in this paper, brings new thinking to a wide range of health care challenges. Central to this reform is research which will provide transparency and clarity on the contribution of nursing within a VBHC approach to service delivery.

This White Paper has provided evidence-based outcomes and case studies that demonstrate the role of nurses as leaders and innovators in the health and aged care systems and in the delivery of patient-centric and cost effective VBHC initiatives.

RECOMMENDATIONS

The Australian College of Nursing calls for a change in how health care is provided in Australia, towards a value-based health care approach. This White Paper asserts that recognising health outcomes that matter to patients will require optimum utilisation of nursing service and recognition of the value nurses bring to the health and aged care systems.

To achieve this ACN recommends that the:

- Amend relevant legislation, including the National Health Act 1953 to enable Registered Nurses access to Medicare Provider numbers and subsequent access to Medicare item numbers for patients of Registered Nurses.
- Australian Government and other relevant bodies work with the Australian College of Nursing and other nursing leaders to accurately document all current VBHC nurse-led initiatives underway, capturing program designs, evaluation results and lessons learnt. This collation and diffusion of information will form an important evidence base for further VBHC reform.
- Australian Government undertake a full feasibility study into the broader application of VBHC including consultation with nurses, identification of appropriate outcome measures, a full cost/benefit analysis of potential gains and identification of organisational and governance hindrances.
- Commonwealth, states and territories, via the National Federation Reform Council (NFRC) adopt patient-centric concepts and outcome measures into the National Partnership Agreement.
- Australian Government and the Independent Hospital Pricing Authority (IHPA) work with the Australian College of Nursing and other key bodies to actively trial the adoption of VBHC into aspects of hospital, community and primary health care funding.
- Australian Government funds research that provides transparency and clarity on the long-term impact of nursing interventions and the contribution of other health professional groups within a VBHC service delivery model.

APPENDIX 1

Nurse-led value-based health care initiatives in Australia

Queensland Health LBC Priorities

Overview
The Government Election Commitment provided for the creation of 400 nurse navigator positions in Hospital and Health Services across Queensland (QLD) to work beyond the traditional silos of care and engage with health care providers to address the holistic requirements of consumers with complex health care needs.

Value delivered
Results six months post implementation demonstrated a reduction in emergency department (ED) visits, decreased day representations to ED within 28 days, reduced readmissions within 28-days, decreased day readmissions, decreased unplanned admissions via ED, reduced bed days and significant cost savings to the health care system[131]. During the first 12 months following implementation of this new nurse led model of care, QLD Health demonstrated an estimated cost saving to the system of $876m whilst achieving outcomes that matter to patients[132].

Integrated care model at Sydney Children's Hospitals Network (SCHN)

Overview
This model is part of an initiative encouraging care coordination for children with chronic conditions. It was designed for children with medical complexity (CMC) and resulted in benefits for the SCHN, health providers and families.

Value delivered
The benefits include reduced hospital encounters, 40% reduction in ED visits, 42% reduction in day admissions, 370 school absences prevented and 50,000km saved in family travel. It is estimated that these findings amount to roughly $5 million in cost savings over a 2-year period[133].

The Quality in Acute Stroke Care Implementation Project

Overview
A collaboration between St Vincent's Health Australia Sydney and Australian Catholic University on the landmark NHMRC-funded QASC cluster trial demonstrated decreased death and dependency following implementation of nurse-initiated, multidisciplinary protocols to manage fever, hyperglycaemia and swallowing post-stroke. A NSW Health collaborative led the successful translation of these protocols into all 36 NSW stroke services.

Value delivered
An independent economic evaluation demonstrated that over a 12-month period, if only 65% of eligible Australians received care in line with these protocols there would be a saving of $281M to the health care system. This work now informs care recommendations in the Australian Clinical Guidelines for Stroke Management. These protocols have been translated into 12 languages and are being implemented into 300 hospitals in 14 European countries[134,135,136].

Sir Charles Gairdner Hospital Patient Blood Management program

Overview
Sir Charles Gairdner Hospital (SCGH) in Western Australia (WA) led the Patient Blood Management (PBM) program which aimed to decrease the risk of blood transfusion by optimising haemoglobin (Hb) and iron stores prior to elective surgery involving significant blood loss. Preoperative optimisation facilitates the post-op recovery of Hb and has the capacity to change transfusion practice. This intervention has significantly reduced transfusion rates in elective joint replacement patients and the model has been replicated at a secondary site and is now rolled out to other surgical specialties at SCGH.

Value delivered
Over 1000 patients across the State of Western Australia are referred to SCGH annually and auditing has shown that 99% of joint replacement patients receive PBM review and care. Educating clinical staff about the impact of blood transfusion and PBM has led to GP clinical pathways and education of health professionals. The overall transfusion rate has fallen by 30% at SCGH since PBM was introduced. This not only has significant cost saving benefits of over $1.2 million annually in WA but has made a major contribution to patient safety and reduced demand on blood supply; ensuring that donor blood is available for trauma or transfusion dependent patients[137].

Pēpi-Pod® Safe Sleep Program

Overview
An international collaboration and local community partnerships, resulted in the Pēpi-Pod® Program, a portable sleep space combined with safe sleep education as a strategy to promote safe infant sleeping and breastfeeding in the context of shared sleeping. The research program targeted QLD's high infant mortality rate in rural and remote Aboriginal and Torres Strait Islander communities with a focus on evidence-based strategies to assist health professionals in delivering safe sleeping messages to families with young infants.

Results
This culturally appropriate and feasible strategy to reduce infant mortality has been integrated into service delivery in rural, remote and metropolitan Aboriginal and Torres Strait Islander communities, across QLD, and more recently in other Australian states and territories[138].

INSPIRED at Calvary Health Care, Canberra

Overview
The Calvary Health Care, Canberra established the INSPIRED trial which integrates specialist palliative care nurses into residential aged care through the use of Palliative Care Needs Rounds. The trial found that regular rounds identified residents most at risk of dying without an adequate plan in place.

Results
The INSPIRED trial included 1700 residents in 12 Residential Aged Care Facilities (RACF) significantly reducing annual costs to the system by $1.759M, reducing hospitals admissions by 67%, reducing length of hospital stay and a 10% reduction in hospital deaths with enhanced consumer satisfaction with more support for residents to die in their preferred place[139,140,141,142]. Importantly, participants were more likely to experience better quality death (including better symptom control, advance planning, closeness with relatives and spiritual care).

RACF staff have reported they are more confident in discussing death and dying with families and planning for symptoms and goals of care at end of life. This initiative supports palliative care in RACFs and normalises death and dying, while providing essential anticipatory prescribing and better decision-making leading to planned care for residents[143,144,145,146].

Nurse Endoscopy – Logan Hospital

Overview
Logan Hospital (QLD) developed the Nurse Practitioner (NP) endoscopy model of care to address the growing demand for endoscopy services. The NP endoscopist has reduced the endoscopy waiting list. The trial found nurse endoscopy is safe and comparable to medical endoscopy in both performance quality and clinical management and has proven cost effective[147].

Value delivered
NP endoscopists performed approximately 4,000 procedures demonstrating a reduction in costs and increased throughput with NPs providing 37% of the backfill when gastroenterologists were absent compared to 18.1% backfill by gastroenterologists[148].

Clinical results for patients have demonstrated both the caecal intubation rate and the adenoma detection rate are higher for NP Endoscopists when compared to Gastroenterologists[149]. Patients seen by NP Endoscopists reported higher levels of satisfaction, felt their privacy and dignity was preserved and were satisfied with the information provided[150]. Overall, NP Endoscopists are more cost efficient and detected 30% more cancer causing adenomas and had higher patient satisfaction[151].

Examples of value-based health care initiatives in Australia that are not nurse-led

The Leading Better Value Care Program

NSW Health is currently moving towards VBHC. It is working on 'value' by improving "the health outcomes that matter to patients; the experience of receiving care; the experience of providing care; the effectiveness and efficiency of care"[152]. NSW Health has developed a Patient Reported Measures (PRM) Framework[153] whereby PRMs serve as a distinct metric that capture the patient's perspective of their care and allows patients and carers to decide on the most appropriate care, provider and intervention. NSW Health's system wide shift to value is evident through its 'Leading Better Value Care program'. This involves rolling out initiatives in phases across all locations and care settings. These clinical initiatives are based on best practice models of care delivery.

Value and outcomes for oral health in Victoria's public dental funding

Overview
In October 2018, Dental Health Services Victoria (DHSV) launched a VBCH model for oral health care in Victoria. The model focused on prevention and early intervention in an appropriate workforce mix.

Value delivered
Findings indicate better health outcomes at lower costs. Specifically, there was a 60% increase in preventative interventions, 80% decrease in dentists performing work that can be provided by other dental professionals, and a drop in failure to attend rates from 18.9% to 5.8%[154].

Choosing Wisely program

Overview
The Choosing Wisely program is an NPS MedicineWise initiative conducted in partnership with health professionals, organisations and societies. It has the potential to reduce costs to the health system by promoting conversations around unnecessary tests, treatments and procedures where little or no benefit or even harm to patients has been demonstrated in the literature[155].

Results
One of the Choosing Wisely programs, Wide Bay Hospital and Health Service (QLD), reported a reduction in unnecessary testing and treatment for patients. Changes in pathology, medical imaging and pharmacy from January-October 2018 to the same period in 2019 had resulted in:

- a 14% reduction in CT head scans and an 8% reduction of leg vein ultrasounds at Bundaberg Hospital
- a 1.3% reduction in CT head scans and a 3.2% reduction in CT pulmonary angiogram scans at Hervey Bay Hospital, despite a significant increase in ED presentations
- an overall reduction in a range of blood tests at Maryborough, Hervey Bay and Bundaberg hospitals
- reduction in opioid pain relief prescribing following surgery, allowing patients to be discharged safely home to start their recovery earlier.

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