Submission to

Independent Health and Aged Care Pricing Authority

IHACPA Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-2026

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Independent Health and Aged Care Pricing Authority (IHACPA) for the opportunity to provide feedback on the draft *IHACPA Pricing Framework for Australian Public Hospital Services 2025-2026* (the draft pricing framework).

The QNMU is Queensland's largest registered union for nurses and midwives, representing over 74,000 members. The QNMU is a state branch of the Australian Nursing and Midwifery Federation (ANMF) with the ANMF representing over 326,000 members.

Our members work in health and aged care including public and private hospitals and health services, residential and community aged care, mental health, general practice, and disability sectors across a wide variety of urban, regional, rural, and remote locations.

The QNMU is run by nurses and midwives, for nurses and midwives. We have a proud history of working with our members for over 100 years to promote and defend the professional, industrial, social, and political interests of our members. Our members direct the QNMU's priorities and policies through our democratic processes.

The QNMU expresses our continued commitment to working in partnership with Aboriginal and Torres Strait Islander peoples to achieve health equity outcomes. The QNMU remains committed to the Uluru Statement from the Heart, including a pathway to truth telling and treaty. We acknowledge the lands on which we work and meet always was, and always will be, Aboriginal and Torres Strait Islander land.

We acknowledge IHACPA's ongoing commitment and consideration of the QNMU's feedback to IHACPA's consultations in determining changes to the Pricing Framework. We reiterate the feedback provided in our previous submissions and raise a number of outstanding issues and opportunities to strengthen IHACPA's pricing for public hospital services.

General comments

The QNMU acknowledges IHACPA's response to a number of issues raised in our recent submission to the *Pricing Framework for Australian Public Hospital Services 2024–25*. We thank IHACPA for making the following commitments to investigate and address our recommendations:

- Consider the inclusion of a new subclass to recognise patient's custodial status in each care type in the next iteration of the Australian National Subacute and Non-Acute Classification.
- Consider mechanisms for improving data collection in the development of the Australian Emergency Care Classification (AECC) Version 2.0, including:
    - Coding of nursing procedural work in Emergency Department Information Systems (EDIS) to improve accuracy of pricing frameworks.
    - Capturing data to identify the impact and flow-on costs of patients presenting to emergency departments (EDs) due to the lack of bulk billing General Practices and limited access to affordable primary care services.
    - Capturing more detailed patient data collection to better map and price all patient care, including the assessment, investigation, intervention, and discharge performed by nurses and Nurse Practitioners (NPs).
- Develop a national strategy to improve integration of virtual care models into pricing and funding for public hospital services, including greater integration of nursing and midwifery-led models of virtual care, such as virtual ED models, models for chronic disease management, hospital-in-the-home, the midwifery community access program, 13HEALTH, and walk-in centres. Given the inevitability of increased use of remote and virtual models of care delivery, timely recognition reflected in pricing and funding mechanisms is urged.
- Consider the following when reviewing the price harmonisation of chemotherapy and dialysis services:
    - Circumstances where it is clinically appropriate for patients to be admitted, such as rural or remote patients who receive care in a metropolitan area.
    - Provision of a clear intent for price harmonisation including that it facilitates best practice care in the most appropriate care setting.
    - Patients discharged and readmitted to hospital in the same day following chemotherapy which results in an increase in the number of episodes of care.
- Include Mental Health Co-Response programs in the *non-admitted community-based mental health services determination* for 2024–25. These programs were introduced as a joint effort with participating Queensland Hospital and Health Services (HHSs) and Queensland Ambulance Service (QAS) to improve the management of people who experience a mental health crisis and offer the opportunity to receive mental health care in their homes.

The QNMU addresses the consultation questions and raises the following additional feedback to be considered in *IHACPA's Pricing Framework for Australian Public Hospital Services 2025–26*.

Consultation questions

What, if any, barriers are there to pricing emergency department services using the Australian Emergency Care Classification (AECC) Version 1.1 without a shadow pricing period for NEP25?

The QNMU acknowledges that IHACPA intends to price ED services using the Australian Emergency Care Classification (AECC) Version 1.1 without a shadow pricing period on the basis that no significant structural changes have been made to the classification. The QNMU raises that section 3.3.2 of IHACPA's consultation paper for the draft pricing framework makes a conflicting statement that the "proposed refinements would require significant structural changes to the structure of the classification or additional data items. These include reviewing the complexity of paediatric patients and possible inclusion of interventions variables to capture investigations and procedures within the classification". The QNMU supports this approach in principle. As IHACPA intends to release the AECC Version 1.1 in September 2024, the nature of changes to the classification are yet to be published and should be further clarified.

Are there any other proposed refinement areas to be considered in the development of an updated version of the Australian Emergency Care Classification?

The QNMU suggests that IHACPA consider providing more detailed data sets to assess the appropriateness of pricing EDs using AECC version 1.1. The QNMU submits that nursing procedural work in EDs be coded in the Emergency Department Information Systems (EDIS). More detailed data collection is required that captures all patient care, including the assessment, investigation, intervention and discharge performed by nurses and NPs should be mapped and priced accordingly.

We also suggest consideration be given to the collection of patient data of those patients who present to EDs due to the lack of bulk billing general practices and/or accessibility and availability issues in finding a timely General Practitioner (GP) or NP appointment. While we acknowledge these patients are captured in the AECC, further refinements may look to include details about the healthcare costs of these type of patients, as well as the impacts to better inform planning and implementation of services to address this issue, given that GP bulk billing and out-of-hours availability will likely remain a chronic issue into the future.

The QNMU notes that the demand for health services and emergency care continues to grow, along with the increasing complexities of patient care. In 2022-23, there were 344 presentations per 1,000 population, equivalent to over 8.8 million total presentations to public hospital EDs in Australia (Australian Institute of Health and Welfare, 2023). To meet these growing demands, the QNMU reiterates the need for greater investment in multidisciplinary care models, including midwifery-led and nurse-led models of care. Examples of nurse-led models of care include emergency department triage and pre-admission clinics prior to surgery, diabetes education, virtual care clinics, stomal therapy and general walk-in clinics (Fedele, 2020). NP-led models of care, such as models that triage low acuity ambulatory patients, have been shown to reduce ED wait times, length of stay and improve patient satisfaction (Plath et al., 2018).

The QNMU also recognises that IHACPA is developing the thirteenth edition of ICD-10-AM/ACHI/ACS (used for classifying admitted patient care) to be released in March 2025. As previously recommended, we ask that IHACPA consider including the Geriatric Emergency

Department Intervention model, which focuses on providing care to older people presenting to EDs, as a key clinical area to identify effective and efficient emergency care.

Are there any barriers or known issues associated with reporting patient level data, specifically in relation to reporting principal diagnosis and patient's age in emergency services?

Errors in diagnosis selection have the potential to disrupt the efficacy of the AECC classification. It should be recognised that the language used for clinical purposes in documentation is often different from what is required by clinical coders to translate information to the required specificity that reflects the complexity of the episode of care. It is recommended that IHACPA provide sufficient supporting materials to assist clinicians and clinical coders in using appropriate diagnosis codes.

We raise a further barrier that the time nurses and midwives are required to spend on clinical documentation can be substantial and burdensome and add to their increasing workloads. The feasibility for hospitals and EDs to use the AECC and adequately report patient level data is impacted by the time required to collect data and the system's interoperability with the ED and hospital. A shortage of clinical coders will place further pressures on ED clinicians to report on patient data and allocate principal diagnoses. To support this outcome, it is important that jurisdictions and IHACPA ensure adequate resourcing is provided to reduce the impact on nurses and midwives to undertake their clinical responsibilities. Further consideration of how electronic medical record (eMR) systems could automatically capture this data may also improve accuracy and reduce the burden on health practitioners.

Are there any other proposed refinement areas to be considered for the Tier 2 Non-Admitted Services Classification for NEP25?

Significant opportunities exist for developing and enhancing nursing and midwifery-led models of care in this space. This could include expanding nurse-led clinics and specialist outpatient services to reduce wait times and support access to care closer to home (Douglas et al., 2018). We continue to encourage exploration of midwifery-led community models. For instance, the Midwifery community access program at the Townsville Hospital and Health Service (HHS). This midwife-led model of care program is about ensuring pregnant women in the community obtain antenatal care early and regularly, rather than just when they give birth. It aims to reduce discharge against medical advice, decrease failure to attend antenatal appointments and reduce high levels of smoking during pregnancy, and consequently improve health care outcomes for Aboriginal and Torres Strait Islander women and their families (Queensland Health, 2020).

We commend IHACPA's commitment to investigate alternate funding models into the current funding framework that have the potential to incentivise the move towards value-based care and a focus on outcomes over volume of services. We suggest the following models for further investigation:

- Virtual emergency department model where patients needing urgent non-life-threatening care by telehealth and are initially seen by an experienced emergency nurse and then a doctor (Queensland Government, 2022a).
- Virtual model of chronic disease management which provide programs on diabetes, heart failure, cardiac rehabilitation, and pulmonary rehabilitation by a range of health practitioners (Smithson et al., 2021).

- 13HEALTH which is a telephone triage system where registered nurses (RNs) can assess symptoms and provide health advice to those seeking health information using a range of protocols to guide the triaging process (Queensland Government, 2020, 2022a).

In addition to exploring new models of care, the QNMU recommends the Tier 2 Non-admitted services Classification:

- Support nurse practitioner's access to 10 series (procedures) to increase sustainability of service models.
- Strengthening home telehealth consultations under 20 series (medical consultation services) for NPs, endorsed midwives and clinical nurse specialists to align with in-person price weighting per specialty.
- Including patient education and monitoring of chronic conditions as activities available under 40 series (Allied health and/or clinical nurse specialist intervention).
- Clarify how non-admitted service events delivered by telehealth that are provided by a medical practitioner and a NP are costed. It is essential to capture all events as this information informs the salaries related to the medical provider and nurse.
- Expanding the list of interventions to capture services provided by nurse navigators.

Given the expected demand for non-admitted care services, further analysis of care coordination service activity is urgently required. The QNMU queries whether the proposed refinements will capture Queensland's newly built and proposed Satellite Hospitals and their associated patient activity for non-urgent emergency care (Queensland Health, 2023). These Satellite Hospitals are designed to take pressure off nearby emergency departments and acute service facilities and provide integrated out-of-hospital community-based care. Broader funding of such models would occupy a space between admitted care and non-admitted care services and could provide a more resilient predictor of costs.

New non-admitted care classification

The commencement of the Australian Non-Admitted Patient Classification Project is welcome, particularly as the approach aims to utilise existing health information such as that in the eMR systems. The QNMU supports this initiative, recognising that when used appropriately, health data can provide an evidence base for planning of care and services, both at the practice level and across the health system.

When refining the Tier 2 Non-Admitted Services Classification, the QNMU recommends considering that non-government and private mental health services operate outside of centralised datasets such as CIMHA or ieMR, resulting in significant information gaps for emergency department clinicians encountering consumers with fragmented or unavailable medical history. Barriers in accessing crucial information, especially during crisis situations, can lead to delays in consumers receiving the help and support they need promptly. The cost of having disjointed data leads to fragmentation and has a significant impact on health budgets. We consider that the integration of data across the care continuum, aged care, private and public must be a priority.

What, if any, barriers are there to pricing admitted and community mental health care services using the Australian Mental Health Care Classification Version 1.1 for NEP25?

The QNMU has long supported increasing the appropriately funded and resourced delivery of mental health care in the community, thereby shifting the patient burden from hospitals and emergency departments and bringing patient care closer to home. While it's not a barrier to pricing community mental health care, pricing all community mental health care models such as medical models, nurse-led models, and other health practitioner models, will increase access to community mental health care. Focusing on the enhanced delivery of community mental health care will provide the much-needed support for outreach services, including Aboriginal Community Controlled Organisations, that bring care closer to home.

The QNMU notes that it will take some time to transition from block funding to Activity Based Funding (ABF) for community mental health services. This includes the need for change management, communication strategies, and workforce capability uplift at the health service level and to evaluate the impact and effectiveness of this transition. A transition of these services from block funding to ABF must ensure that this does not reduce capacity within the system, but rather facilitates increased access to these essential services (Palmer et al., 2014). We ask that IHACPA be cognisant of the potential consequences of ABF, in particular where small services may not have the activity necessary to support such a model. Any ABF model must capture all activity so that the true cost of services is recognised and supported.

We suggest the following consideration for refining the next version of the *Australian Mental Health Care Classification (AMHCC)* (Version 2.0):

- Significant challenges exist with data quality in mental health, especially for non-admitted and other community-based services. While this challenge is broader than mental health, a strong governance and accountability framework, appropriate and effective implementation of ABF and transparent public reporting on performance and outcomes are required and are critically dependent on quality data.
- Consider the complexity and variability of mental health services and the needs of patients. Many people with chronic and complex mental health conditions will require longer term, coordinated care packages involving multiple providers across the health and human services sectors.
- The scope and approach of the National Disability Insurance Scheme (NDIS) is an important consideration in enhancing the AMHCC. Consideration needs to be given to how mental health and NDIS systems work together, or alongside each other, to support the complexity, type and amount of care consumers require.

Are there any persisting barriers to collecting activity data following the COVID-19 pandemic response? If so, what potential strategies could IHACPA use to support states and territories overcoming these barriers?

The COVID-19 pandemic has disrupted some important aspects of the public hospital systems, including teaching, training and research activities. The experience of our members shows that many nursing and midwifery students could not undertake hospital-based placements or research projects required as part of their tertiary curriculum. The QNMU suggests further consideration is required about the methods of teaching, training and research activities for nurses and midwives, such as creating more online training activities where appropriate and exploring alternative, safe methods to conduct research.

The QNMU takes the opportunity to acknowledge that the growing adoption of technologies and artificial intelligence engaged in healthcare, must be met with adequate education and training opportunities for nurses and midwives. As the largest workforce in the healthcare sector, nurses and midwives must be actively involved in consultations regarding the design, implementation, monitoring and evaluation of technology integration at all levels, that significantly impact the nursing and midwifery workforce.

What evidence can stakeholders provide that demonstrates the costs and changes to models of care associated with the COVID-19 pandemic response have persisted into 2022–23, or changed over time?

During the COVID-19 pandemic, nursing and midwifery-led models of care have been undoubtedly successful in harnessing new technologies to adapt to changing service delivery requirements and provide quality, safe care to patients. Some notable models engaged during the pandemic include virtual wards, hospital in the home (HITH), telehealth, nurse-led respiratory and fever clinics, vaccination pop-up clinics, and dedicated post-acute and long COVID clinics and triaging models and assessment tools such as in-car triage/fever clinics and open-air consultations. NP-led models of care were also utilised to provide after-hours emergency care in rural urgent care centres to reduce the burden of excessive after-hours on call duties for rural GPs, while improving access to quality care (Wilson et al., 2021).

Restrictions applied to maternity care services during the pandemic impacted the approach midwives undertook in providing woman-centred care. The pandemic fostered new ways of working for midwives, including hybrid and mixed modes of care delivery and partnerships, such as the use of telehealth in combination with face-to-face models of care. There was a notable shift away from hospital-based antenatal consultations towards community-based midwifery-led consultations to facilitate access to services where it was needed.

Some of these nurse and midwifery-led models engaged in response to the pandemic have become embedded elements of the health system, such as expanded MBS telehealth items to support virtual models of care. Other enduring models include:

- HITH which has continued to be utilised to support patients, particularly in residential aged care facilities, to avoid unnecessary hospital admission or re-admission. The role of nurses in HITH model is critical in coordinating care across acute and non-cute settings and providing communication between patients, families, aged care residential facilities and primary health services. The model has successfully been expanded and adapted to reduce hospital admissions during the COVID-19 pandemic as well as to minimise the risk of COVID-19 exposure to staff and patients (Queensland Government, 2022b).
- Nurse-led practice models, such as walk-in clinics in Tasmania and the Australian Capital Territory have been successful in providing people with treatment and preventative healthcare, alleviating wait times in EDs, and supporting workforce shortages and increased demands for health services (ACT Government, 2023). Queensland has acted on the success of interstate nurse-led walk-in clinics and has recently (March 2024) introduced a number of nurse-led clinics, staffed by NPs and nurses with a focus on the healthcare needs of women and girls, as part of the *Queensland Women and Girls Health Strategy 2032*.

These examples highlight the value of nurse-and midwifery-led models of care that are flexible and adaptable to the needs of the community, particularly within primary care and in regional,

rural and remote areas (Beks et al., 2023). We continue to advocate for the incorporation of nurse and midwifery-led models associated with the pandemic, into ongoing service delivery. The QNMU continues to emphasise that the lessons from the COVID-19 pandemic must be retained and implemented, to ensure that health systems are prepared and resilient in the face of future pandemics.

What factors should be considered in refining the calculation and application of the Indigenous adjustment, so that it reflects the costs of public hospital services for Aboriginal and Torres Strait Islander peoples across Australia?

The Royal Commission into Aged Care Quality and Safety recommendations are important in the context of pricing for residential aged care, as they set the expectation for the provision of aged care, which must be priced and funded accordingly (Commonwealth of Australia, 2021). Cultural safety is an integral part of the provision of aged care services. The QNMU recommends that IHACPA consider the legitimate and unavoidable costs associated with delivering culturally safe care and incorporate this into the recommended price for the provision of residential aged care.

This is consistent with recommendation 52 from the Royal Commission into Aged Care Quality and Safety Report that:

1. *The Australian Government should block fund providers under the Aboriginal and Torres Strait Islander aged care pathway (see Recommendation 47) on a three-to seven-year rolling assessment basis.*
2. *The Pricing Authority should:*
    a. *set the funding of the Aboriginal and Torres Strait Islander aged care pathway following advice from the Aboriginal and Torres Strait Islander Commissioner, and*
    b. *annually assess and adjust the block funding on the basis of the actual costs incurred while providing culturally safe and high-quality aged care services to Aboriginal and Torres Strait Islander people in the preceding year*

Should the ICU adjustment be restricted to a list of eligible hospitals? If so, what factors should be considered in determining the level of ICU complexity, required to be eligible to receive the ICU adjustment, noting that individual units cannot be identified in the current national data collections?

Recognising the impacts of increased patient longevity, co-morbidities and acuity on healthcare presentations, the QNMU supports the IHACPA's recommendation from the NEP24 consultation to complete a review on "eligibility criteria and adjustment methodology to inform future Determinations".

Are there any barriers to a tiered adjustment that would allow for different ICU adjustment prices to apply, based on the characteristics of eligible hospitals or episodes of care within those hospitals?

Feedback from the Australian and New Zealand Intensive Care Society state branches to the *Pricing Framework for Australian Public Hospital Services 2024–25* outlines many patient care and economic benefits for this to be implemented. The QNMU support's IHACPA's recommendation to undertake a comprehensive review.

Are there any barriers to including a fixed national weighted activity unit adjustment for eligible hospitals, regardless of activity levels?

Consultation for the *Pricing Framework for Australian Public Hospital Services 2024–25* suggested that a variety of funding models should be considered. The QNMU supports that a larger body of work is required in this regard. It should also be recognised that patients in ICU have different acuity and may require extra care and additional resources that an hourly rate would not completely compensate for. The QNMU would support further consideration regarding a tiered approach to funding, with acuity and resourcing taken into account.

What quality assurance approaches are being implemented at the hospital or state and territory level that should be considered by IHACPA to apply to national data collections?

The QNMU supports IHACPA's intention to undertake a quality assurance review of the National Hospital Cost Data Collection (NHCDC) 2022-23 for NEP25. To ensure accurate information is submitted to the NHCDC and subsequently available for NEP determination, we support validation and quality assurance processes that are undertaken during the NHCDC Data transformation process to ensure high quality data is submitted to IHACPA. The QNMU does not raise any quality assurance approaches but supports further consultation with key stakeholders to improve the cost and activity data collection for the NHCDC framework.

What changes would enhance the user experience and functionality of the National Benchmarking Portal to inform improvements in public hospitals, and policy making?

The QNMU has consistently supported public reporting of health data that will enable consumers to make informed choices and increase transparency and accountability around performance and spending. The National Benchmarking Portal provides a first-time opportunity to compare differences in activity, costs and efficiency at similar hospitals to inform discussions about differences in cost, efficiency and patient care. Public and private hospitals already participate in clinical indicator programs run by accrediting bodies such as the Australian Council on Healthcare Standards (ACHS). These indicator programs would provide a useful starting point for hospital wide and clinical specialty indicators that may be suitable. We also believe the top ten Australian Refined Diagnosis Related Groups (AR-DRGs) for each facility would be valuable public knowledge as they provide a clinically meaningful way of relating the number and type of patients treated in hospital and the resources required by the hospital.

The QNMU considers that the following indicators should be publicly available:

- Patient Reported Outcome Measures (PROM);
- Patient Reported Experience Measures (PREM);
- Average length of stay;
- Readmission rates;
- Costs to patients for health services;
- Post-surgical mortality rates;
- Adverse events;
- Healthcare-associated infections;
- Presentations to emergency departments;
- Waiting and treatment times in emergency as well as the proportion of patients staying for four hours or less;

- Elective surgery waiting and treatment times; and
- Perinatal indicators such as premature births, planned and unplanned caesarean sections, breastfeeding and access to continuity models of care (which are known to positively impact these outcomes).

This enhanced level of transparency provides important information to hospitals and health services and the wider community for the purpose of reporting, prioritising safety and quality interventions and evaluation. We reiterate the need for the portal to ensure total confidentiality and security of patient data in this process.

What impact has the introduction of the pricing approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions had on public hospital service delivery?

While we support IHACPA's intention to improve patient outcomes in these areas, the funding approach taken to reduce funding or remove funding for sentinel events, may potentially cause an undue bias against hospitals where these situations are more likely to occur. While sentinel events may be a result of human error, there are often other system level components that might drive or contribute to adverse outcomes. It is important to look beyond human errors to report on and address all components that lead to these types of adverse events. Reduction of funding, for any reason, potentially has a negative impact on care provision, as facilities try to manage reduced budgets. The nature of sentinel events is that they are generally unintended and unexpected and withholding funding from an episode of care where one occurs is not likely to improve outcomes.

To inform the further development of safety and quality measures, are there other pricing- related approaches that could be used to reward high quality care? How can IHACPA identify such care in national data collections?

The QNMU continues to advocate for the implementation of nurse-to-patient and midwife-to-patient ratios in all public and private hospitals. Evidence shows there has already been successful implementation in specified public wards and aged care facilities in Queensland. Recent research to assess the effects of implemented minimum nurse-to-patient ratios in Queensland found that minimum nurse-to-patient ratio policies are a feasible approach to improve nurse staffing and patient outcomes with good return on investment (McHugh et al., 2021). For instance, the McHugh study found that if study hospitals staffed at a 4:1 ratio for a 1-year period, then more than 1595 deaths would have been avoided and hospitals would have collectively saved over $117 million (McHugh et al., 2021). This is a considerable improvement in quality of care and cost outcomes for hospitals that cannot be ignored.

Unqualified newborns

We commend IHACPA for continuing to prioritise the review of the funding methodology for unqualified newborns as a key objective for the 2024-25 work program. Establishing and maintaining safe workloads has been a long-term priority for the QNMU and ANMF state and territory branches across Australia. After years of campaigning against dangerously high workloads and patient safety concerns through QNMU's "Count the Babies" campaign, the state government has recently passed the *Health and Other Legislation Amendment Bill (No.2) 2023* to legislate minimum midwife-to-patient ratios in Queensland. This legislation makes Queensland the first jurisdiction to clarify that every baby will be counted as a separate patient when they are staying in the same hospital room as their birth parent. Although this is a

significant milestone for Queenslanders, the QNMU emphasises that funding methodology for unqualified newborns remains a critical issue for all jurisdictions to address.

We oppose the concept of qualified and unqualified infants and will do all we can to have the care of all babies recognised in the funding framework. Revising the pricing model at a national level to include newborn babies will support state and territory governments to amend midwifery staffing to include newborns in patient allocations. The QNMU believes this will have a significant impact on supporting the delivery of safer, higher quality midwifery care and foster more sustainable workloads and conditions for midwives.

We recommend that IHACPA align bundled pricing with evidence-based models of care to reinforce the implementation of best practice in public health services. We welcome further discussion and consultation with IHACPA to address this issue, in the interest of delivering high-quality maternity care across Australia.

Maternity care

The QNMU calls for a review of the current funding structures for maternity care, shifting to a women-centred funding approach and a greater focus on preventative care. We continue to advocate for the expansion of midwife-led models of care, as the research indicates that most pregnant women achieve better outcomes with primary health care by a known midwife (Sandall et al., 2016). A recent systematic review published in *Cochrane* has found that women who receive midwife continuity of care models, compared to those receiving other models of care, are less likely to experience a caesarean section or instrumental vaginal delivery, and may be less likely to experience an episiotomy and are more likely to experience a spontaneous vaginal birth. Women also reported more positive experiences during pregnancy, labour, and postpartum. Additionally, there are reported cost savings in the antenatal (care during pregnancy) and intrapartum (care during labour and birth) period (Sandall et al., 2024).

A key example of midwifery models of care is the Midwifery Group Practice (MGP), which provides continuity of care, where midwives work with mothers and babies during pregnancy, birth and post birth. They also enable women, particularly those in rural and remote areas, to give birth where and when they want to. MGPs can operate without an obstetrician, while ensuring one is available if required. Evidence shows continuity of care models such as MGP result in 24% reduction of pre-term births and a 16% reduction in pregnancy and neonatal loss (Sandall et al., 2016). MGPs demonstrate cost savings for health services due to reduced intervention and hospital stays and have been shown to cost 22% ($5,208) less per pregnancy than other models of maternity care (Callander et al., 2021). This is just one example that exhibits that reduction in intervention rates afforded to midwifery continuity models translates to lower costs to the health service.

Key actions we continue to advocate for include:

- Moving towards a bundled pricing model for maternity care, as recommended by IHACPA's (formerly titled IHPA) *Final Report of IHPA and the Bundled Pricing Advisory Group 2017.*
- Implementing all recommendations from the *Strengthening Medicare Taskforce Report 2022* and the *MBS Participating Midwives Reference Group Report 2021*

- Publicly funding midwife-led services where sexual and reproductive healthcare is provided as a component of holistic care, including, but not limited to, Long-Acting Reversible Contraceptive prescription and insertion and Medical Termination of Pregnancy services.

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