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AMA submission on the Pricing Framework for Australian Public Hospital Services 2021-22

The Independent Hospital Pricing Authority
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Thank you for the opportunity to comment on the 2021-22 Public Hospital Pricing Framework. Our comments are outlined below and organised under the chapter headings used in the consultation paper.

1. Changes to hospital service type, models of care, and the cost of these adapted services in response to COVID-19.

The AMA welcomes the Independent Hospital Pricing Authority's (IHPA) willingness to identify and adapt the Pricing Framework 2021-22 to reflect the impact COVID-19 has had on service design, delivery, and the cost of these adapted services. State governments and public hospital managers are in the best position to provide the data for these analyses.

The AMA's concern is that these are not the only COVID-19 cost impacts on public hospitals that need to be incorporated in the 2021-22 Pricing Framework.

Delayed patient care as a direct result of COVID-19 will have a substantially cost impact on public hospitals now and into the future. The impact will be greatest for the two largest jurisdictions (Victoria and New South Wales) where infection rates were highest, but all jurisdictions will have patients who have delayed treatments. Comprehensive public hospital services activity data already published by New South Wales for the quarter April to June 2020 compared to the same period in 2019[1] shows:

- Acute care admissions fell by 17 per cent.
- Non acute care admissions fell by 19 per cent.
- Mental health care services fell by 11 per cent.
- Non-urgent elective surgery fell by 67 per cent.
- Semi urgent elective surgery fell by 27 per cent.
- Urgent elective surgery volume was maintained (only down by 2 per cent).

[1] Bureau of Health Information. Healthcare Quarterly, Trend report, Emergency department, ambulance, admitted patients and elective surgery, April to June 2020. Sydney (NSW); BHI; 2020. Accessed 29 September 2020 https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0011/603569/BHI_HQ_APR-JUN_2020_Trend_Report.pdf

Each patient who has not accessed the public hospital services due to COVID-19 will still require the treatments and/or diagnostic services they need but will have to wait longer for it. Public hospital treatment rates to respond to the increased volume of patients waiting for treatment are largely fixed, and very difficult to scale up quickly. Even a small reduction in the treatment rate due to COVID-19, will be cumulative and cause a substantial increase in the number of patients already waiting ahead of new patient arrivals[2]. These knock on effects to public hospital waiting lists will be very hard for public hospitals to overcome.

The clinical impact of delayed treatment is well documented in the literature. Consequences include increased morbidity, a higher risk of complications and adverse events when the patient is admitted, a longer patient stay and an elevated risk some patients will die during an admission and/or while waiting for care. The longer patients must wait for treatment, the more likely they will require an emergency admission and complications. These factors will increase costs and average length of stay per separation.

A reduction in non-admitted cancer screening during COVID 19 has a strong potential to reduce the pre COVID-19 rate of early cancer detection and substantially increase public hospital costs of cancer treatment. The early detection of cancer in a precancerous stage, or when the cancer is still small, improves patient outcomes and survival rates. Cancer that is detected early is also considerably less expensive than later stage cancer treatments that require surgeries and expensive cancer drugs and possible palliative care. Chemotherapy and immunosuppression will also carry a higher risk of patient complications in a COVID-19 environment[3]. If the suppression of screening is prolonged because of COVID-19, the long-term health impact for affected patients will very likely be detrimental and public hospital treatment costs will be higher than treating early stage cancers.

A recent AIHW report on Cancer Screening and COVID-19[4] shows COVID-19 has had the greatest negative impact on the volume of breast cancer screening. Screening volume dropped by 145,000 between January to June 2020 compared to the same period 2 years earlier. These comparison years reflect the biannual screening schedule. The impact on screening for cervical cancer and bowel cancer is not yet known because in the same year as COVID-19, the testing frequency for cervical screening and bowel caner was changed, and bowel cancer screening target groups were expanded.

Staffing shortfalls in public hospitals due to potentially preventable infection or enforced quarantine affects not just the COVID-19 positive staff member but also the close contacts of a COVID-19 positive hospital doctor, nurse and other staff who become infected. The negative health impacts of COVID-19 infections for hospital staff may mean some highly trained staff cannot return to normal work patterns for long periods. Any level of potentially preventable staff absences amongst key hospital staff will reduce the number of public hospital patients that

[2] Richardson D and Mountain D (2009) '*Myths versus facts in emergency department overcrowding and hospital access block*'. Medical Journal of Australia, Volume 190 Number ,6 April 2009 accessed on 6 October 2020 https://www.mja.com.au/journal/2009/190/7/myths-versus-facts-emergency-department-overcrowding-and-hospital-access-block

[3] Rosenbaum L (2020). *The Untold Toll - The Pandemic's Effects on Patients without Covid*. The New England Journal of Medicine, Medicine and Society pp2368-2371. (Ed) Debra Malina. accessed 28 September 2020 https://www.nejm.org/doi/pdf/10.1056/NEJMms2009984

[4] Australian Institute of Health and Welfare (2020) 'Cancer screening and COVID-19 in Australia' accessed 8 October 2020 https://pp.aihw.gov.au/reports/cancer-screening/cancer-screening-and-covid-19-in-australia/contents/did-fewer-people-screen-for-cancer-during-the-covid-19-pandemic

can be treated, reduce public hospital efficiencies, and increase the average cost of care. Data from the Australian Institute of Health and Welfare shows public hospital resource constraints meant patients were waiting too long for public hospital treatment even before the effects of COVID-19. The inability of public hospitals to keep up with demand and provide timely patient care is summarised in the AMA 2020 Public Hospital Report Card[5].

AMA members who are emergency physicians also describe the loss of ED efficiencies due to changes in patient flow necessitated by COVID-19. These changes include:

- Clinical and epidemiologic screening.
- Systems redesign and infrastructure improvements. These include negative pressure, ventilation, physical separation of suspected COVID-19 patients and non-suspected COVID-19 patients, and staff.
- System redesign into streaming of suspected and non-suspected COVID-19 patients.
- Division of workforce to COVID-19 streams en-bloc to prevent cross contamination.
- Additional time for emergency staff to don and doff PPE and slower work rates due to the continual need to wear respiratory protections and take precautions. The time costs of donning and doffing will apply across the hospital.
- Slower patient flow from point of Ambulance arrival (including inter-hospital transfer)
- Emergency Departments area designation, and admission to different wards of hospital to separately stream suspected/non suspected COVID-19 patients.
- Time lags for patient flows while staff wait for patient COVID-19 swab results prior to flow movement within the hospital. This increases the capacity strain on emergency departments and compounds the reduce rate of patients flowing through the emergency department and from emergency to hospital wards.
- The establishment of extended emergency department reach that would not be 'core business' pre COVID-19. For example, virtual emergency departments, community care, screening clinics, public screening, outbreak management.

These necessary COVID-19 response measures dilute the number of available clinicians conducting the core business in an emergency department and exacerbate the slow down in patient flows and existing staffing shortfalls.

Ongoing health issues for patients who have recovered from acute COVID-19 will add substantial costs to public hospital treatment in the short and long term. Not all of these post infection complications are fully understood. Cardiac and respiratory complications appear to be most commonly reported, including diastolic dysfunction such as cardiac failure, with possible impacts continuing even decades later. COVID-19 related long term neurological affects remain unclear at this early stage.

A recent article in the Journal of the American Medical Association (JAMA)[6] reported a study that showed surgical patients with either asyptomatic or symptomatic COVD-19 increases the risk for perioperative morbidity and mortality. A case-controlled analysis from Italy, published

[5] Australian Medical Association, 2020 AMA Public Hospital Report Card https://ama.com.au/ama-public-hospital-report-card-2020

[6] *Kibbe M (2020), Surgery and Covid-19, Journal of American Medical Association (JAMA). 324(12):1151-1152. doi:10.1001/jama.2020.15191*

by Doglietto et al,[3] showed that the 30-day risk of mortality for patients with COVID-19 undergoing surgery (n = 41), compared with patients without COVID-19 (n = 82), was significantly higher (19.51% vs 2.44%; odds ratio [OR] 9.5 [95% CI, 1.8-96.5]). The odds for perioperative pulmonary complications also were significantly higher, as were the odds of thrombotic complications.

The longer diagnosis and treatment of chronic disease, cancer and other conditions are delayed, the more intensive and costly the care will be when treatment is provided. Cancer patients may also be negatively affected because treatment regimes involving chemotherapy and immunosuppression will carry a higher risk of complications in a COVID-19 environment[7].

The national pricing model for 2021-22 needs to fully compensate public hospitals for all increased treatment costs caused directly or indirectly by COVID-19. Adjustments to cost weights for the following patient cohorts should be considered a priority:

- Former COVID-19 positive patients.
- All patients who are not admitted within clinically recommended timeframes due to COVID-19 delayed care. This includes patients who have planned treatments cancelled/deferred during COVID-19 and patients who are stuck in a backlog of patients waiting for treatment but not yet made it onto official waiting lists.
- Patients who delayed screening during COVID-19 and are later diagnosed with cancer.
- Patients who are silently deferring treatment or stuck in the backlog of patients who are waiting for an outpatient assessment/consultation/diagnostic test etc and not treated within clinically recommended timeframes.

Public hospitals should not be financially penalised for higher patient treatment costs, due to either:

- COVID-19 caused delays to patient care.
- COVID-19 caused complications for existing conditions.

2. Pricing for Safety and Quality

The AMA agrees that rates of avoidable public hospital patient complications should be as low as possible. The AMA disagrees that funding penalties are an effective way to achieve this outcome.

There is no credible international or Australian evidence to demonstrate a causal link between funding penalties and fewer hospital patient complications[8] [9]. The preference for funding penalties appears to be at odds with the requirement in the Pricing Framework to ensure that all aspects of funding are based on the best available evidence.

[7] Rosenbaum L (2020). *The Untold Toll - The Pandemic's Effects on Patients without Covid*. The New England Journal of Medicine, Medicine and Society pp2368-2371. (Ed) Debra Malina. accessed 28 September 2020 https://www.nejm.org/doi/pdf/10.1056/NEJMms2009984

[8] Australian Commission on Safety and Quality in Health Care (2015) Supplementary Briefing Joint Working Party: Safety and Quality

[9] Cochrane (2019) 'Pay for performance (payment or penalty methods to encourage hospitals to increase quality of care) https://www.cochrane.org/CD011156/EPOC_pay-performance-payment-or-penalty-methods-encourage-hospitals-increase-quality-care#:~:text=The%20aim%20of%20this%20Cochrane,care%2C%20resource%20use%20and%20equity.

The AMA understands there is no intention to subject the pricing framework penalties to external, independent review even though they took effect in 2018 and shadow pricing goes back to 2015. If there is evidence the public hospital funding penalties, as designed, do have a robust statistical association with lower complication rates that has been subject to external review, but not published, AMA would welcome advice to this effect.

The continuation and expansion of funding penalties for safety and quality is a missed opportunity to adopt an evidence-based approach to support public hospitals reduce patient complication rates. There is much stronger evidence to show a direct correlation between lower patient complications and public hospital doctors' access to benchmarked hospital data. The AMA fully supports IHPA's establishment of a portal to make benchmarked public hospital data available to all public hospital doctors and managers.

In this COVID-19 environment the current penalties for sentinel events, hospital acquired complications and avoidable readmissions should be suspended for the Pricing Framework 2021-22 until the clinical consequences of COVID-19 are well understood in the literature and incorporated into the Pricing Framework risk adjustments. The next best option, if penalty suspension is not possible, is to minimise the magnitude of funding penalties. Of the funding options presented in the consultation paper to penalise avoidable readmissions, option three is most workable in a COVID-19 environment.

The AMA does not support IHPA's proposal to adopt the funding penalty under option one which is the most severe and is blind to the higher complication risks in a COVID-19 environment.

3. Public-Private neutrality

The AMA does not oppose the proposed change to the public-private neutrality guidelines, provided that funding adjustments for private patient elections do not leave treating public hospitals financially worse off when a patient elects to use their private health insurance. This would ultimately penalise patients who have paid for private hospital insurance but cannot use their policy in a public hospital when treatment is required. Many patients have insurance policies that are less comprehensive because the premiums are affordable. These policies regularly leave the patient with large out-of-pocket costs when used in a private hospital. The AMA would also expect that any change to public-private neutrality would preserve the patient's right to select a treating specialist, and the specialist's right to private practice.

4. Classifications used to describe and price public hospital services

AMA welcomes the proposed refinement of non-admitted services in Tier 2 including the proposed new clinic nurse/specialist/allied health clinics for pain management and exercise physiology.

5. Setting the national efficient price for activity based funded public hospitals

It is not clear from the consultation paper, or from Clause A47 of the Addendum, whether IHPA must ensure the NEP settings take account of differences in input costs between jurisdictions, including wages growth, or whether A47 requires IHPA to begin full recognition of public hospital wages growth. If the latter, AMA welcomes this change.

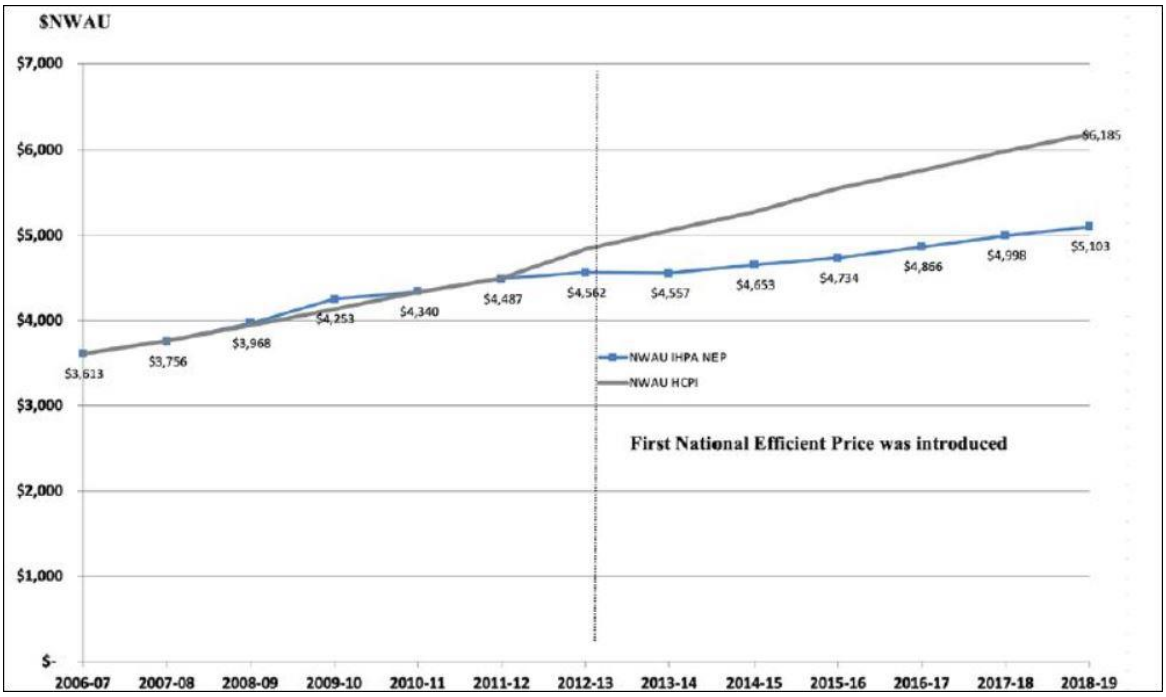
AMA has previously identified the NEP does not take into full account wages growth each year. NEP indexation for 2020-21 was just 2.1 per cent. Nursing salaries alone will increase by 2.5 per cent in the same year. Public hospitals are service organisations, and clinicians, nurses, allied health providers, and other staff are key to providing hospital services. The NEP should fully recognise public hospital wages growth and index it into the NEP each year, without off-setting hospital cost increases by the efficiency gains achieved the year before. The current methodology pares back Commonwealth contributions to match artificially depressed NEP growth rates and passes year-on-year hospital input costs to State governments.

The current indexation formula is unsustainable and is contrary to requirements set out in A46 of the Addendum which reads:

A46. In determining the national efficient price, the IHPA must:

a. "have regard to ensuring reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness and financial sustainability of the public hospital system."

The graph below illustrates the indexation shortfall under current NEP arrangements.



The Figure above compares Commonwealth funding price indexation under current arrangements to Australian Bureau of Statistics (ABS) Health Consumer Price Index. Up until the 2012-13 year (the first National Efficient Price), the two series were almost identical in each year. After the introduction of Activity Based Funding and the National Efficient Price, the NEP increases at a very slow rate. The Health CPI series captures what would have occurred without the productivity gains achieved through the innovation of public hospital staff. The savings banked by the Commonwealth should be re-invested back into the system to boost public hospital service levels and contribute to the investments public hospitals will need to make to

achieve the next round of efficiencies. This reinvestment is just a small part of the additional funding public hospitals need.

6. Costing private patients in public hospitals and the private patient correction factor

The AMA supports the aim of adjusting private patient revenue to ensure public hospitals have no financial incentive to prioritise insured patients ahead of public patients in waiting lists. AMA's in-principle support is conditional on:

a. Ensuring a final adjustment methodology does not financially penalise public hospitals if they accept a private patient election. (See comments earlier in this submission under the heading *Public-Private neutrality on page 6 of this submission.*)

7. National efficient cost

The fixed plus variable model used to determine Commonwealth contributions for smaller rural hospitals with lower patient volumes, appears to be reasonable. The AMA welcomes IHPAs willingness to accept concerns raised by stakeholders as issues become known, and undertake additional modelling as needed. This is a very important and welcome approach, given the complexity of public hospital pricing.

8. Alternate funding models to promote innovative models of care in lower cost settings

The demand pressures on public hospitals are at unmanageable levels, and hospitals are struggling to provide treatments within clinically recommended timeframes. The AMA agrees that funding flexibility is urgently needed to support the development of new and innovative models of care in lower cost settings. The AMA would support bundled care for well-defined patient pathways that span multiple care settings, but these must be hospital clinician designed and led. The bundled payment must not exclude Commonwealth contributions for additional hospital services if these are needed for patients whose treatment pathway is atypical. The proposal to measure and benchmark outcomes for patients treated under bundled care is very welcome. It is an evidence-based approach to clinician led, incremental improvement in outcomes and efficiencies.

As the population ages and rates of chronic disease continue to rise, new models of flexibly funded care to support chronic disease patients stay well in the community are urgently required. The challenge is often that the diversity and range of services needed by some chronically unwell patients usually extend beyond the boundary and funding limit of activity based funded services.

The Northern Health Healthlinks model is the most plausible, given its focus on care coordination and improving the patients' access to existing services rather than attempting to fund new services. AMA notes that this capitation trial was assisted by Medibank Private through the use of their CarePoint packages and the use of three Medibank funded CarePoint coordinators. Deploying this model on a broader scale will likely require similar levels of funding.

Critical success factors for innovative funding models

- Avoid the top down lens that limits new innovative models of care to those that most easily align to existing ARDGs.
- Develop innovative models of care from the ground up. Hospital clinicians are best placed to develop innovative models of care based on their knowledge of clinical care pathways, patient needs, hospital systems and constraints.
- Design flexible funding to support the new models. This is especially the case for new models of integrated care designed to reduce hospital presentations for chronically unwell patients.
- Measure and benchmark outcomes for patients treated through innovative models of care to identify best performing models and assist incremental improvement in outcomes and efficiencies. Share the learnings and scale out where appropriate.
- Bundled funding for treatments with defined patient pathways is most likely to produce the early wins because it provides patients specific flexibility.
- Don't expect efficiencies in the first couple of years. Allow time for the efficiencies to be found, models of care adapted and bedded in.
- Don't financially punish early failures. These are most likely to provide the insights for improvement.

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