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IHPA Pricing Framework 2023-24

AMA submission to Independent Hospital Pricing Authority Consultation

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Impact of COVID-19 on NEP22

COVID-19 continues to have an unprecedented impact on the national public hospital system, which is expected to continue into the foreseeable future. The AMA agrees that it is essential that its impact on activity and cost is adequately accounted in the national pricing model.

In our previous submissions the AMA called for personal protective equipment (PPE)costs to be taken into account as a direct cost of COVID-19.[1] International evidence also indicates that surgeries in the time of COVID-19 are more expensive than in normal times due to costs associated with infection prevention and use of PPE.[2]

Furthermore, the delay in elective surgeries as the direct result of COVID-19 pandemic is already resulting in more complex surgeries and post-surgical recovery care needs for patients who were affected by the delays. This cost must be factored into any future pricing model.

The Pricing Guidelines

The AMA welcomes IHPA reviewing pricing guidelines in 2022. As the pricing guidelines stem from the Addendum to the National Health Reform Agreement 2020-25, the AMA acknowledges that they reflect the Addendum.

However, it is becoming increasingly apparent that the current funding is failing to support timely access to quality health services. This is evident by the growing waiting times in emergency

[1] AMA Submission IHPA Pricing Framework 2022-23 https://www.ama.com.au/articles/2022-23-public-hospital-pricing-framework
[2] A J Fowler, T D Dobbs, Y I Wan, R Laloo, S Hui, D Nepogodiev, A Bhangu, I S Whitaker, R M Pearse, T E F Abbott, Resource requirements for reintroducing elective surgery during the COVID-19 pandemic: modelling study, British Journal of Surgery, Volume 108, Issue 1, January 2021, Pages 97–103, https://doi.org/10.1093/bjs/znaa012

departments nationwide, as well as growing elective surgery waiting lists. While COVID-19 has exacerbated the issue, wait times in emergency departments as well as for elective surgery were growing even before the pandemic.[3] Therefore the AMA argues that pricing guidelines calling for efficiency are at counter to the current community need for a sustainable network of public hospital services. The AMA hears regularly from members that there is capacity to conduct elective surgery in the hospitals they work in, with availability of both the staff and the operating theatres, however there is not enough funding available for the actual surgeries to be performed.

Scope of Public Hospital Services

The AMA notes that the General List of In-Scope Public Hospital Services includes other outpatient services. The ‘hidden waiting list’ - outpatient wait times for specialists in the public hospital system - has been another growing problem burdening the public hospitals and inflicting unnecessary pain on the patients. Numbers available at State/Territory level indicate that wait times can be sometimes years for patients that should be seen as outpatients by specialists within 30 days of referral.[4]

The AMA argues that in the same manner that IHPA is considering factoring in the costs of delayed surgery in the pricing model, it should also consider factoring in the cost of delayed access to specialists in the outpatient clinics. Delayed access to a specialist often results in delayed access to elective surgery, leading to patients presenting at emergency departments, having more complex health conditions, and requiring longer recovery.

Classifications used to describe and price public hospital services

The AMA is supportive of the proposal to recognise frailty as a cost driver for subacute care, as well as the proposed impairment group episodes in the rehabilitation branch. The AMA does not see any barriers to using AN-SNAP Version 5.0 to price subacute and non-acute services.

Cost of admitted mental health care in public hospital is an important factor impacting the overall cost of care. In 2020-21 there were 250,653 public hospital admissions for mental and behavioural disorders.[5] Total number of mental health care patient days in public hospitals in 2020-21 was 2,231,799. For comparison number of subacute and non-acute care patient days in 2020-21 was 2,855,588. In total, 10.5% of all patient days in public hospitals in 2020-21 were taken up my mental health care type patients.[6]

Furthermore, public hospital emergency departments (EDs) continue to be overburdened by patients presenting with mental health conditions. In 2020-21 there were close to 400,000 presentations of patients with alcohol/drug abuse and alcohol/drug induced mental disorders

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[3] Australian Medical Association 2022. AMA Public Hospital Report Card 2022. https://www.ama.com.au/articles/ama-public-hospital-report-card-2022

[4] See for example the Outpatient Clinic stats for Tasmanian Health, indicating that wait time for urgent referral in the Tasmania’s Southern Health Region for paediatric ear, nose & throat specialist appointment is 472 days, or 802 days for urgent neurosurgery https://outpatients.tas.gov.au/clinicians/wait_times/wait_times;

[5] https://www.aihw.gov.au/reports-data/myhospitals/content/data-downloads Why did people receive care Table 4.8

[6] https://www.aihw.gov.au/reports-data/myhospitals/content/data-downloads Admitted Patient Care 2020-21 Why did people receive care Table S4.3

and patients presenting with psychiatric illness.[7] Evidence suggests that patients presenting at emergency departments with mental health conditions tend to spend more time in EDs waiting for in-patient care/available beds than any other cohort of patients.[8]

The growing cost and reliance on public hospitals to pick up the lack of care in the community and lack of access to appropriate care before issues escalate to the point where hospitalisation is the only solution, emphasise the importance of finding and funding adequate care in the community for growing number of people suffering from poor mental health. Community mental health care must be funded and utilised to divert cost from public hospitals.

However, this does not mean that the cost of community mental health care should be stripped to the bare minimum. We have seen that when primary care is inappropriately funded, it results in increased pressure on public hospital services. To avoid this, adequate efficient cost should be determined that aligns with the overarching guidelines that require both efficiency *and* sustainability. The AMA argues that efficiency needs to be considered in a broader context of the value that community mental health services provide to those utilising the service, but also in the context of the overburdened public hospital services. Therefore, the new pricing model structure that incentivises more direct consumer care activities is welcomed, however, efficiency should not be the main criteria in funding community services. Mental health care is complex and mental health care in the community should be adequately compensated for the complexity of care it provides.

Setting the National Efficient Price

The AMA welcomes IHPA considering additional cost input pressures in the development of NEP Determination 2023-24. These will need to take into consideration the high inflation rate, cost pressures stemming from higher commodity prices and prices of utility services, as well as limits to procurement of essential tools and diagnostic agents due to international circumstances.[9]

The AMA supports IHPA conducting a reinvestigation of the adjustment for patient transport in rural areas. The AMA notes a recent report by the NSW Parliamentary Committee on Rural Health found that

> "a lack of regional Patient Transport Services is being supplemented by Ambulance NSW, resulting in paramedics frequently attending patients who do not require emergency care and reducing Ambulance NSW's capacity to respond to emergencies, and that this comes at great cost to patient and paramedic safety."[10]

[7] AIHW 2022 Emergency Department Care 2020-21, Table S41 https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care
[8] ACEM 2020, Nowhere Else to Go, https://acem.org.au/getattachment/52e10bfa-e6b9-435e-a4c8-c65e47c2e46f/Nowhere-else-to-go-report_final_September-2020.pdf?lang=en-AU
[9] See for example: Therapeutics Goods Administration TGA 2022. Alerts: Shortage of iodinated contrast media (contrast) diagnostic agents https://www.tga.gov.au/alert/shortage-iodinated-contrast-media-contrast-diagnostic-agents#:~:text=The%20Therapeutic%20Goods%20Administration%20(TGA,current%20supply%20is%20very%20limited.
[10] NSW Parliament Legislative Council 2022. Report 57: Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

The Report recommended that the NSW Health reviews the funding available for transport and works collaboratively with other stakeholders to ensure appropriately timed affordable, transport services are available to support patients.

The AMA also welcomes IHPA's consideration of a new adjustment for socioeconomic status of patients. This is important because the data demonstrate that patients from lower socio-economic backgrounds tend to have more chronic health conditions and tend to be more reliant on the public hospital system.[11] Often the costs associated with attending GP appointments and lack of access to bulk billing GP practices present a barrier for patients from lower socioeconomic backgrounds, resulting in them not seeking timely treatment as they cannot afford the associated costs. The 2020-21 data shows that patients from the lowest socio-economic area of usual residence had almost twice the number of public hospital separations as the patients in the highest areas.[12]

Setting the National Efficient Cost

In our submission to 2021-22 National Pricing Framework, the AMA welcomed the 'fixed-plus-variable' model.[13] The AMA prefaced our support with IHPA's willingness to accept concerns raised by stakeholders as issues become known, and undertake additional modelling as needed. The AMA is not aware that any such concerns have been raised with IHPA by relevant stakeholders, but we are aware that the recent NSW report found that "activity-based funding is not appropriate for all rural and remote based hospitals with many marginally viable at best under this funding model."[14] The AMA notes that IHPA plans to continue to use the 'fixed-plus-variable' model for the NEC Determination 2023-24, but would encourage IHPA to continue its commitment to undertake additional modelling as needed.

Future funding models

The AMA is supportive of investigating ways to implement alternative funding models, particularly the ones that enable continuity of care and are patient centred. Any model of care that incentivises and appropriately enables provision of care in the community, without outsourcing medical care to less qualified health practitioners, and reduces the burden of ageing population and chronic disease on the public hospital system will be supported by the AMA.

However, the AMA warns that the implementation of innovative models and person-centred care is currently dependent on the availability of and proper collection of healthcare data, in particular

https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf

[11] AIHW 2020. Health across socioeconomic groups https://www.aihw.gov.au/reports/australias-health/health-across-socioeconomic-groups

[12] AIHW 2022. Admitted Patient Care 2020-21, 3 Who used admitted patient services, Table 3.6 https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients

[13] Australian Medical Association 2020.

[14] NSW Parliament Legislative Council 2022. Report 57: Health outcomes and access to health and hospital services in rural, regional and remote New South Wales https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf

the lack of consistency around the national individual healthcare identifier data. This is also the precondition for any future implementation of value based healthcare.

With regards to innovative models of care being trailed, the AMA notes a recently announced initiative for telehealth consultations in emergency departments, with Northern Health receiving funding from the Victorian Government to roll out the program state-wide.[15] Evaluation of that trial may provide some direction towards future development or expansion of similar models of care.

With regards to setting the Setting the national efficient price for private patients in public hospitals, the AMA would like to draw IHPA's attention to the information the AMA receives from members that pertains to remuneration of specific procedures performed in private hospitals, including for public patients.

Specifically, AMA members note the difference in price/remuneration for disciplines like gynaecology, urology, plastics, some general surgery, which are remunerated at a low price, unlike for example orthopaedics or bariatric surgery, which are remunerated at a higher price. This has resulted in some States/Territories surgeons being asked by private hospitals to vacate fully utilised operating lists, so they can be replaced with better remunerated theatre activity/surgeons. And while it is understood that IHPA's role is setting the NEP and NEC for public hospitals, the AMA argues that the consequence of this 'cherry picking' of surgical services is lack of access to care for both public and private patients in the private system. This behaviour by private hospitals also tends to undermine the value proposition of private health insurance.

The AMA supports the principal of equivalent theatre renumeration across disciplines to avoid these problems. Furthermore, we believe it is important that IHPA understands how the information it shares with the private sector is utilised, to be able to consider the implications of the information it produces and how it is being used.

Pricing and funding for safety and quality

As stated in our submissions to the pricing framework consultations in the previous years, the AMA agrees that preventable hospital complications and sentinel events should be as low as possible, but we continue to disagree that funding penalties are an effective way of achieving the reduction.

The AMA welcomes IHPA's further work on examining the ways that avoidable and preventable hospitalisations could be reduced. The AMA believes that, with the growing ageing population living with multiple chronic health conditions, the reduction will only be possible with the better funded and better supported primary care and care in the community. Bearing in mind that the primary care is separate from public hospitals both in terms of its governance and funding, the AMA is concerned that there is a lot of cost shifting happening, where public hospitals are

[15] Puls IT Magazine 2022. Northern Health rolls out virtual emergency department statewide https://www.pulseitmagazine.com.au/news/australian-ehealth/6618-northern-health-rolls-out-virtual-emergency-department-statewide

expected to deal with the consequences of the evident underfunding of primary care and care in the community.

Furthermore, public hospital emergency departments have become the avenue of choice for the residential aged care facilities to shift older patients whose conditions are not being adequately managed in residential aged care due to lack of qualified staff and lack of access to primary care. The AMA estimated that in 2020-21, 27,569 hospital admissions per year from nursing homes were potentially preventable, and that this comes at an annual cost of $312 million (figures calibrated for 2020–21).[16] Also, a research paper by the Royal Commission into Aged Care Quality and Safety in 2020 reported that there were 18,267 hospital re-presentations from nursing homes in 2018–19, patients who re-present to ED within 30 days of an overnight hospital stay.[17] In the current circumstances, the hospitals could be penalised for the representations of these patients, through no fault of their own.

General Comments

The AMA notes that there are a number of policy issues that are outside of the scope of this consultation and IHPA remit that will require broader Commonwealth and State/Territory governments action, including amendments to the Health Reform Agreement, to improve Australia's public hospital system.

The AMA hopes that all of this will be considered by IHPA and the national bodies when deliberating and planning for safety and quality related reforms.

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[16] Australian Medical Association 2021. Putting Healthcare Back into Aged Care Report. https://ama.com.au/sites/default/files/2021-04/130421%20-%20Report%20-%20Putting%20health%20care%20back%20into%20aged%20care.pdf

[17] 6 Royal Commission into Aged Care Quality and Safety (2021). Hospitalisations in Australian Aged Care: 2014/15–2018/19. Research Paper 18. https://agedcare.royalcommission.gov.au/sites/default/files/2021-02/researchpaper-18-hospitalisations-australian-aged-care.pdf