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RACP Submission to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24

July 2022

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Foreword

The RACP welcomes the opportunity to provide input to the Independent Hospital Pricing Authority (IHPA)'s Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023-24 (the Pricing Framework).

We are appreciative of IHPA's consideration of past RACP submissions and acknowledge that COVID-19 has impacted IHPA's capacity to undertake planned initiatives to refine the pricing model. We note IHPA's expanded role in providing advice on home aged care pricing from 1 July 2023 and that a separate framework for pricing Australian residential aged care services will be developed and released later in 2022.

The principles and policies adopted by the Pricing Framework are of importance to RACP membership which includes consultant physicians of various specialties working in the public hospital system. We are pleased to see IHPA's commitment to continuous collaboration, consultation and assessment to update the national pricing model and deliver valued-based care.

Our submission addresses the consultation questions in relation to:

- Impact of COVID-19
- Classifications used to describe and price public hospital services
- the National Efficient Price (NEP)
- the National Efficient Cost (NEC)
- Future Funding Models

1. Impact of COVID-19

COVID-19 has caused a transformation in Australia's health system, including the reconfiguration of hospital wards, time-limited suspension of non-urgent surgery and procedures, and the expansion of telehealth. These changes have had far-reaching impact on activities in public hospitals.

The RACP supports the use of the 2020–21 costed activity data, which includes a full financial year of data impacted by the COVID-19 pandemic response, as a basis for the NEP Determination 2023–24 (NEP23). We note that IHPA is aware of the potential significant longer-term implications of COVID-19, including the potential for more complex future surgeries, the need for additional personal protective equipment and impact of workforce shortages and staffing requirements to support implementation of COVID-19 safe policies and procedures.

Feedback received suggests that in assessing COVID-19 impacts on the 2020–21 data in the development of NEP23, specific considerations should be given to the following:

- **Changes in casemix, hospital resources and treatments**

COVID-19 has resulted in significant changes to some health services, which in turn affect casemix, hospital resources and length of hospital stay. The 2020–21 costed activity data might reveal less activity but relatively stable hospital costs. There is evidence showing that the ED presentation rates for frequent attenders dropped immediately by 36% and continued to drop by 1% per week during the second wave of COVID-19 in Victoria[1]. Reported physician experience indicates that some hospital procedures might have increased to expedite discharge e.g., it was reported that patients with diabetic foot ulcer were given definitive early amputations rather than in-hospital conservative therapy. The reduced bed situation remains a considerable issue in subacute services.

[1] Jessup, Rebecca Leigh, et al. "Impact of COVID-19 on emergency department attendance in an Australia hospital: a parallel convergent mixed methods study." *BMJ open* 11.12 (2021): e049222.

To gain a more accurate picture of changes in hospital activities, it is important to compare the length of hospital stay in acute and subacute care in 2020-21 data in contrast to previous years, measure the number of beds closed or substituted to home-based beds, and investigate whether prolonged waiting times for NDIS funding, services and residential care due to COVID-19 reduce service provision and carer availability

- **Use of historical state-based funding models**

The use of 2020–21 data is likely to underestimate the costs associated with medical workforce, due to delayed costs. This is illustrated in the case of the Southern Adelaide Local Health Network, which was turned into a maternity centre without additional funding provided. Consequently, the national pricing model may incorporate a marked increase in nursing costs, but no increase in medical staffing despite a significant increase in patients over the year. As such, special attention needs to be paid to the use of historical state-based funding models (with no direct adjustment for casemix) in repurposed health services due to COVID-19.

- **Workforce recruitment and backlog of public patients**

Rural and regional hospitals have incurred additional costs related to more competitive recruitment of junior medical practitioners in addition to years of diminished international medical graduate staffing levels.

Fear of contracting COVID-19 has led to avoidance and delay in hospital care, which may influence patient prognosis or health outcomes. The health system's attempts to catch up on the backlog of public patients will be most likely to drive up the overall costs. Setting appropriate NEP and NEC requires comprehensive examination of admitted patients, in addition to noting the leading cause of admission.

- **The value of Occupational and Environmental Medicine Services**

The ongoing impact of COVID-19, such as Long COVID and a range of workforce challenges in public hospitals, has proven difficult to manage. In our 2021 submission, we provided the evidence of benefits of embedding occupational and environmental medicine (OEM) specialists in hospitals through referencing the example of the Mater Hospital group. The occupational physician-led return to work approach in the hospital contributed to substantial reductions in WorkCover insurance premiums and resulted in significantly more workers being supported to return to work.[2].

Lack of funding currently prevents government departments such as Queensland Health from embedding OEM specialists in most hospitals, even though abovementioned results suggest that adoption of this approach could have significant cost benefits[3]. The value of embedding occupational medicine specialists in public hospital system has not been realised and should be considered by IHPA in light of the ongoing and expected impacts of COVID.

- **Potential work safety cost to be considered for inclusion**
  - Indoor workplace safety review and installation of safe ventilation system to ensure safe indoor air ventilation and reduced risk of COVID-19 transmission; the use of high-efficiency particulate air (HEPA) filtration systems to enhance air cleaning
  - Transmission outbreak investigations and control improvements to prevent transmission, staff loss and prolongation of inpatient stays
  - COVID-19 prevention, including increased rapid antigen testing, and extra vaccinations

[2] Written feedback provided by AFOEM member. More information available on request.
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2. Classifications used to describe and price public hospital services

2.1 ICD-11 and AN-SNAP Version 5.0

The RACP notes that the preparation for the implementation of ICD-11 is currently underway and welcomes the release of AN-SNAP Version 5.0 which will be used to price admitted subacute and non-acute services.

We wish to highlight the greater needs of NDIS applicants and participants. Experience of our members shows that these patients often face impediments to discharge from hospital, have increased complications and care requirements and that their care services require greater hospital resources.

With respect to ICD-11, we recommended that the new classification systems should not make clinical information coding more difficult during a coding workforce shortage. It is essential that the existing and new classifications systems account for patients with intellectual disability, NDIS applicants and NDIS participants.

As with AN-SNAP Version 5.0, the number of patients with complex issues such as physical disability, intellectual disability, behavioural issues, substance abuse and mental health is on the rise. This is the case for both rehabilitation patients and patients with disability. It highlights the need for AN-SNAP Version 5.0 to better describe the increasingly complex and extensive health needs of these patients, including patients who required disability support but are not registered as NDIS participants and NDIS patients requiring extended hospital stay.

2.3 Teaching, training and research

COVID-19 has disrupted some important aspects of the public hospital systems – teaching, training and research. Experience of our members shows that many medical students could not undertake hospital-based research projects required as part of their university curriculum. This new situation requires careful consideration and shifts in the way we conduct teaching, training and research activities, such as creating more online projects and training activities and exploring safe ways to conduct research.

3. Setting the National Efficient Price (NEP)

3.1 Adjustments to the NEP

The RACP notes that due to the impact of COVID-19, IHPA deferred investigation of the proposed adjustments for NEP22 to focus on refinements to the pricing model to account for the impact of COVID-19. Our 2021 submission to IHPA's Pricing Framework consists of important feedback on the proposed adjustments in relation to patient transport in rural areas, Indigenous adjustment and genetic services. These remain valid and we ask for IHPA's renewed consideration. Additionally:

- **NDIS applicants and participants**

People with disability often have poor health and functioning compared to those without; they are at a greater risk for secondary conditions such as cardiovascular disease, diabetes are higher and have more risk factors that affect morbidity and mortality[4]. A new adjustment for NDIS applicants and participants is recommended to ensure that hospitals are adequately resourced to provide quality care to patients with disability, both while in hospital and in post-discharge community care. Complexities for patients with disability include:

- The lack of suitable accommodation for people under 65 years old with significant disability who require 24-hour care
- Disability support workers who may require additional training and education from the hospital staff to be qualified to provide patient care, in addition to disability support in the community

[4] Forman-Hoffman, Valerie L., et al. "Disability status, mortality, and leading causes of death in the United States community population." *Medical care* 53.4 (2015): 346.

- Difficulties in maintaining communication with disability support workers to ensure that the patient is adequately followed up.

These complexities in caring for patients with disability often require additional hospital resources and staffing, which are currently unaccounted for in the NEP.

- **Older patients with cognitive impairment and Behavioural and Psychological Symptoms of Dementia**

In our 2021 submission, we suggested a review to consider cases where appropriate provision has not been made for higher costs of patients with special needs in hospitals. This is particularly pertinent to the significant and growing cohort of patients with cognitive impairment and non-cognitive behavioural and psychological symptoms of dementia (BPSD). These patients can find a hospital stay and removal from their normal home extremely distressing and this can cause an escalation in problematic behaviours that take time to settle sufficiently for the patient to return to their usual home. Care of these patients often requires 24-hour special nursing and security services and longer stays and these needs should be adequately considered in the DRG classifications. We contend that the current DRG classification do not currently adequately reflect the level of care necessary.

3.2 Additional cost input pressures

- Anecdotal evidence suggests that public child development assessment teams are experiencing increased referrals with a corresponding increase in demand for hospital-based child assessment services to support functional assessments that need to be provided in order to access the NDIS. The increased demand for these hospital-based assessment services, together with long waiting lists, is certain to exert cost input pressures on the pricing model. The impact of any delay in care would be highest among children and families in rural and regional areas, those of a lower socioeconomic status and those struggling with mental health concerns.
- Hospital workers' compensation claims have become more prevalent under COVID-19. With an increase in Long COVID cases and the associated potential for permanent disability and the need for treatment, the costs of workers compensation claims and cover are expected to continue to rise. This warrants a review of the cost of hospital workers compensation claims and the development of a strategy to reduce these costs.
- IHPA's measures at the moment penalise acute surgery even when it may improve patient experience. The national pricing model should prioritise the benefits of timely access to surgery, even if that is through acute pathways. There needs to be clarity from IPHA what it is doing on hospital-acquired complication (HAC) and avoid readmissions.

3.3 Priority initiatives to refine the national pricing model

We note that IHPA's capacity to undertake other initiatives to refine the national pricing model has been affected by its investigation of refining the pricing model to account for COVID-19 in the development of NEP22. In addition to IHPA's planned initiatives (e.g., harmonising price weights and setting the NEP for private patients in public hospitals), additional initiatives worth of IHPA's consideration are:

- COVID-19 has prompted the shift of our health system towards virtual care. This has transformed the way many health services are delivered especially in non-admitted settings, allowing treatments to be provided during quarantine and lockdowns. An investigation of better funding for models for virtual care is critical to the effective and cost-effective use of virtual care in public hospitals.
- The current funding model does not support the integration of disability services with health services because of the separation of funding streams. It is critically important to refine the pricing model to account for disability services so as to ensure integration of these sectors.

4. Setting the National Efficient Cost

4.1 Cost pressures facing regional or remote hospitals

Regional and remote hospitals have faced greater pressures from the impact of COVID-19. In developing NEC23 for regional or remote hospitals, we recommend that IHPA also considers the following:

- The lack of suitably qualified disability support workers and providers may make discharge into the community more challenging and may carry higher risk of complications.
- Inflation stemming from and exacerbated by supply chain disruptions in regional and remote areas
- Increased cost of staff accommodation and relocation costs

4.2 Specific areas of data for independent quality assurance process

We note that IHPA is exploring the development of an independent quality assurance process for the public health expenditure included in Local Hospital Networks and Public Hospital Establishments National Minimum Data Set. This would ensure high quality input data for cost modelling for the NEC Determination.

We welcome IHPA's annual commissioning of an independent financial review (IFR) to assess whether all participating hospitals have included appropriate costs and patient activity in the National Hospital Cost Data Collection (NHCDC)

Specific areas of data that IHPA should focus on are patients with complex needs, such as disability, substance abuse and misuse, mental health diagnosis, intellectual disability, homelessness or unhealthy/unsafe housing. These factors contribute to the need for increased care while the patient is in hospital, and also may require increased follow up post-discharge to manage complex and co-morbid conditions. Collection of this data will assist in providing better quality care in future that is supported by an appropriate funding model.

Another area of data focus could be workers' compensation claim and outcome data, including employee injuries, lost time injuries, return to work statistic and premium rates, given the problems related to ongoing COVID-19 impacts and a range of workforce challenges mentioned earlier.

5. Future Funding Models

5.1 Alternate Funding models

The RACP supports the incorporation of alternate funding models into the current activity-based funding (ABF) system that have the potential to incentivise the move towards value-based care and a focus on outcomes over volume of services.

We look forward to the release of the IHPA's draft business rules for a capitation model for chronic kidney disease, which is currently in consultation with its advisory committees and will serve as a guidance on the types of innovative funding models being considered by IHPA.

Innovative models of care for IHPA's consideration include:

- The RACP Model of Chronic Care Management features a multidisciplinary model of integrated, collaborative care to bridge primary and specialist care. It addresses a care gap for intermediate level patients with chronic complex conditions, which links in with the drive to reduce unnecessary and potentially preventable hospitalisation. This model features a capitation financing method for team-based care that would include salaried hospital physicians being able to provide services in an ambulatory setting. Under this proposal, the core healthcare team would comprise a care coordinator, GP and consultant physician but with scope to include other healthcare practitioners (e.g., allied health, specialist nurses) as appropriate. Members of the core team can come from the public hospital sector, in which case their employer would collect a per patient payment in lieu of their time;

alternatively, they would collect payments themselves if they are private practitioners in the community.

- To address the increased demand for the hospital-based child assessment services, the Neurodevelopmental and Behavioural Paediatric Society of Australasia (NBPSA) proposes that an innovative model of care be based on employment incentives for regional health services where there is a limited pool of qualified staff prepared to work in the public health system. This would assist early diagnosis and intervention for children with neurodevelopmental and behavioural concerns and reduce their long-term disability. Having such a national funding model would ensure consistent and standardised approach to these essential services, e.g., staffing based on population size/complexity to ensure equitable access to services.
- The WorkCover service of the Mater Private Emergency Care Centre (MPECC) has been delivering services through telehealth. It has demonstrated that many injured employees can be reviewed and returned to light duties through a telehealth consult which is reimbursed from WorkCover. IHPA approved the inclusion of telehealth video consultations delivered by emergency departments on the General List of In-Scope Public Hospital Services 2022–23. Similar video consultations with OEM physicians could be provided to any healthcare worker who is injured at work or has an occupational illness (e.g., COVID19).
- Investigate whether frailty impacts on the cost of acute care in the same way it is recognised as a cost-driver for subacute care.

5.2 Innovative models of virtual care and services

We welcome IHPA's exploration of innovative models of care and services related to virtual care, with an initial focus on telehealth video consultations delivered by emergency departments. Virtual care such as telehealth consultations is supported by patients and doctors as an effective way to access specialist care. The use of telehealth confers many benefits: reducing patient waiting times, unnecessary travel, and attendance at outpatient clinics; enabling patients to be managed closer to home or in the home; and supporting rural patient access to health services. Such models of care can be utilised in many services, including child assessment.

Virtual care data are currently not adequately collected and monitored. These data could be captured via telehealth records or obtained from the telehealth solution vendor logs. While outpatient telephone consults are best captured through a hospital's outpatient activity log, inpatient telephone consults – either in a hospital or in the home – are less well recorded.

Other considerations for virtual care services:

- Introduce incentives such as appropriate funding for hospital in the home to reduce the use of hospital-centred care, where clinically appropriate
- Explore a range of local health district led outreach models of care to develop appropriate and adaptive funding models.

6. Final comments

Considering that the Pricing Framework is part of the national health and funding reform strategy, it is critical that national health service priorities of quality, equity, and sustainability, inclusive of workforce, are at the centre of Framework development.

The focus on evidence-based practice needs also to be strengthened throughout the Framework, which should clearly address the issues of clinical governance, including training, guidelines, audit and feedback.

Hospital reform is a component of the much-needed whole-of-system reform and must be closely aligned and connected to the work on strengthening primary health care and improving integrated care which have the greatest potential to keep people out of hospitals.

We thank IHPA for considering the RACP submission and look forward to the opportunity to contribute to IHPA's work further.