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RACP submission to the Pricing Framework for Australian Public Hospital Services 2024-25

July 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 21,000 physicians and 9,000 trainee physicians, across Australia and Aotearoa 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 and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) appreciates the opportunity to submit feedback on the Independent Health and Aged Care Pricing Authority (IHACPA) Pricing Framework for Australian Public Hospital Services 2024-2025.

In line with the objectives set out in the National Health Reform Addendum, the RACP is dedicated to supporting improved service integration, interconnectedness and responsiveness in our Australian hospital services.

Our submission addresses several key areas of the consultation:

- Classifications to describe and price Public Hospital Services
- Setting the National Efficient Price (NEP)
- Setting the National Efficient Cost (NEC)
- Future Funding Models
- Pricing for Quality and Safety.

Classifications to describe and price Public Hospital Services

AN-SNAP 5.0 for pricing subacute and non-acute care

The RACP notes that IHACPA will use AN-SNAP 5.0 to price admitted subacute and non-acute services for NEP24. AN-SNAP 5.0 modestly adjusts AN-SNAP 4.0, has no major structural changes and its most significant improvement is an acknowledgement of frailty as an important cost driver. The RACP supports the IHACPA work to develop a measurement framework for frailty to ensure standardised reporting against this cost driver.[1]

As outlined in our 2022 submission to the Pricing Framework, the RACP strongly believes that factors such as substance use, homelessness, mental health and physical and intellectual disability are additional significant cost drivers that should be considered in pricing hospital services. Complex needs, often presenting across the lifespan, require more intensive resourcing for appropriate hospital care, including higher staff-to-patient ratios, longer consultations, additional specialist to GP coordination, adjustments to facilitate support staff where applicable, appropriate safety for support workers on site, as well as additional discharge from hospital support. The persisting siloes between hospital care, social care, secondary and primary care systems create additional imposts for inpatient physicians who need to negotiate and coordinate continuity of care for their patients. The ongoing refinements of the AN-SNAP method must pay closer attention to the variability and complexity of care.

To use one illustrative example, patients with intellectual disability present for outpatient and inpatient care with additional layers of complexity due to their disability and associated comorbidity profile. The requirements for disability support workers to provide adequate support and facilitate access and participation in health care must be considered and accommodated across pricing approaches, including for subacute and non-acute services. Moreover, adults with intellectual disability are often frequent users of hospital services compared to peers without disability; they also experience high rates of preventable adverse events in hospital. Additional time, care and disability support for presentation to hospital/hospital admission need to be factored in the Pricing Framework and applicable funding models.

As such, the omission of this and other mentioned cost drivers in the Pricing Framework underestimates the actual costs of delivering hospital services. The RACP recommend that IHACPA follow the example of frailty to develop appropriate classifications within AN-SNAP 5.0 to address these complex needs.

The RACP notes the absence of rural and remote considerations in AN-SNAP 5.0. This is despite the Australian Institute of Health and Welfare (AIHW) long-standing acknowledgement of rurality as a cost driver

[1] Development of the Australian National Subacute and Non-Acute Patient Classification Version 5.0 Final Report [online]; australian_national_subacute_patient_classification_version_5.0_-_final_report_-_december_2021.pdf (ihacpa.gov.au)

that increases costs per person per episode of hospital admission, travel costs for ambulance services, and public hospital separations compared to metropolitan areas.[2] Rurality should be a category for ongoing refinement over and above those for complexity in priority patient groups.

The RACP stress that standardised data collection at each stage of AN-SNAP 5.0 implementation and refinement is essential for accurate classification and pricing of public hospital services. Accordingly, data collection should be standardised across all existing and future categories.

AECC 1.0 and telehealth

IHACPA is currently investigating areas for refinement within the Australian Emergency Care Classification (AECC), which will incorporate an analysis of the new structural features of emergency service provision. The RACP highlights remote consultation activity, including telehealth, as an important component of this refinement work, where these consultations are used to facilitate outbound assessment or treatment services, and where the patient may not have physically arrived at an emergency care setting. The current classification is based on in-person attendances to quantify episodes of care, even though remote consultations now play an increasingly vital role in emergency care. Remote consultation use has been accelerated by the COVID-19 pandemic and some evidence shows these remote consultations have reduced emergency care among frequent attendees from priority patient populations.[3]

Our RACP members report that remote consultations, including telehealth, are used to provide emergency support to vulnerable and priority populations with frailties or complex needs off-site, assess urgency of physical transfer, receive and review remote monitoring data, as well as train third parties in emergency management procedures.

Other unaccounted costs in emergency care and non-admitted care

In refining classification for pricing emergency care and non-admitted care, it is important to consider additional resources (personnel, time, support, equipment) required to support or rehabilitate patients for the discharge from care process, or to support independent living in the community. Special consideration needs to be given in this context to rurality, regionality and associated operating costs and operational supply limitations. These additional resources are particularly critical in delivering emergency care and non-admitted care for older people, people with mental health conditions, people experiencing homelessness, people with a disability, or people with other complex needs.

With specific regard to emergency care, it is vital that the activities of all sub-specialties involved in the delivery of an emergency episode of care be captured for reporting and costing purposes, including sub-specialties that may not have a direct patient interfacing role, such as clinical pharmacology and toxicology.

The RACP supports the IHACPA work to investigate amendments to Tier 2 for non-admitted care services which will be required to better capture the activity delivered by innovative and integrated multidisciplinary models of care, including virtual or remote care. Amendments should consider and capture the varied and targeted needs of First Nations people, rural and regional communities, children, people with disability, including intellectual disability, and people with specific chronic conditions, to support local innovation and integration in quality service delivery in non-admitted care settings. Costing and funding for appropriate access to care need to go beyond primary and specialist services to include allied health professionals such as physiotherapists, occupational therapists, social workers and others.

Mental health care

Given the known mismatch between health service supply and patient needs in rural, regional and remote areas[4], the IHACPA should consider and account for the transition of mental health care services from block funding to Activity Based Funding for NEP24. Estimating the adequate level of future cost in these areas may

[2] Australian Institute of Health and Welfare [online]; Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure, Summary - Australian Institute of Health and Welfare (aihw.gov.au)
[3] Jessup RL, Bramston C, Beauchamp A*, et al* Impact of COVID-19 on emergency department attendance in an Australia hospital: a parallel convergent mixed methods study *BMJ Open* 2021;11:e049222. doi: 10.1136/bmjopen-2021-049222
[4] Australian Institute of Health and Welfare [online]; Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)

be challenging, particularly considering reported shortages of mental health services[5]. Special attention should be given to the costing and funding implications of mental health care in these underserved regions.

Setting the National Efficient Price (NEP)

The impact of COVID-19

The IHACPA commitment to assessing the ongoing impact of the COVID-19 pandemic on hospital activity and costs data for NEP24 is welcomed. The RACP notes the development of the NEP24 will use 2021–22 costed activity data, representing a full financial year of activity that has been impacted by the pandemic response. The RACP anticipates this data will capture funded activity when the number of COVID-19 cases was lower in Australia relative to other countries until early 2022, when case numbers rose due to the Omicron variant in December 2021, and the cumulative incidence rose to 231,000 cases per million people by 30 April 2022.[6]

COVID-19 costing adjustments have an ongoing application to NEP24 as the disease continues to impact working arrangements in hospital settings. Our RACP members report that in some hospital settings inpatient ward rounds remain extended by 30-60 minutes due to the continuing application of infection prevention and control arrangements. In our 2022 submission to the Pricing Framework the RACP highlighted work safety costs need consideration in the NEP, including indoor safety reviews, installation of safe ventilation, air filtration systems, transmission outbreak investigations and control improvements, staff loss, absence and leave, compensation claims, locum replacements, increased rapid antigen testing and extra vaccinations. Additional resource pressures have also been placed on hospital services providing outreach vaccinations to people with a disability in secluded spaces. The RACP continues to call for assessment of the impact of these factors on NEP24 costings.

Exploration of the latest Australian Institute of Health and Welfare (AIHW) data for the 2021-22 financial year and other data sources indicate additional factors need to be accounted in assessing the impact of the COVID-19 pandemic for NEP24:

COVID-19 impact on emergency department presentations

- AIHW datasets for 2020-21 and 2021-2022 reveal large increases in emergency department presentations on a population level compared to previous years. COVID-19 continued to drive a large patient influx to emergency departments in 2021-22, only modestly reducing from 2020-21 levels by 0.2% overall.[7] This must be reflected in NEP24.

Elective surgery admissions

- In 2021–22, all jurisdictions except Tasmania saw a reduction to public elective surgery admissions due to COVID-19; this decrease was evident across all categories of surgery urgency.[8] The AIHW has not yet released elective surgery data for 2022-23, but the RACP urges attention to this dataset so changes in the rate and cost of elective treatments can be accounted for in NEP24. The health system efforts to catch-up on elective surgery backlogs for public patients suggests the need for this area to be monitored and estimated to arrive at appropriate costings.

Surging influenza cases

- Influenza cases in Australia declined significantly when the COVID-19 restrictions were in place and preventive behaviours that minimised transmission encouraged. Cases of influenza have risen steadily since the COVID-19 restrictions have lifted, either alone or in tandem with other respiratory

[5] Gardiner FW, de Graaff B, Bishop L, Campbell JA, Mealing S, Coleman M. Mental Health Crises in Rural and Remote Australia: An Assessment of Direct Medical Costs of Air Medical Retrievals and the Implications for the Societal Burden. Air Med J. 2020 Sep-Oct;39(5):343-350. doi: 10.1016/j.amj.2020.06.010. Epub 2020 Jul 15. PMID: 33012470; PMCID: PMC7362830 [online] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7362830/

[6] Australian Institute of Health and Welfare, The impact of a new disease: COVID-19 from 2020, 2021 and into 2022 [online]; Chapter 1: The impact of a new disease: COVID-19 from 2020, 2021 and into 2022 (aihw.gov.au), p.2

[7] Australian Institute of Health and Welfare, Australia's hospitals at a glance, December 2022 [online]; Australia's hospitals at a glance , Impact of COVID–19 on hospital care - Australian Institute of Health and Welfare (aihw.gov.au)

[8] Australian Institute of Health and Welfare Elective surgery activity [online]; Elective surgery activity - Australian Institute of Health and Welfare (aihw.gov.au)

viruses such as respiratory syncytial virus (RSV).[9] [10]The impact of influenza and other respiratory infections on the health workforce, the consequent delivery of hospital services and the pricing of hospital services should be considered for NEP24.

Long COVID-19

- While prevalence estimates are contested, the World Health Organization notes that current evidence indicates that approximately 10-20% of COVID-19 patients are impacted by Long COVID[11]; on a population-wide level these figures will impact many Australians. There is a need to improve data collection and classification work to gauge the impact of long COVID on acute, sub-acute and non-admitted public hospital services.[12] This work is necessary for a more complete picture of the implications of COVID-19 on hospital pricing for NEP24 and beyond.

Public health physician and other non-procedural subspecialty activity during and beyond COVID

- Public health physicians are a crucial part of pandemic response, infectious and non-infectious disease prevention and management for both individuals and communities.[13] Public health physicians play a vital role within jurisdictional health systems, extending to public hospital services, yet much of their work cannot be easily classified as an episode of care/service per admitted hospital patient, which makes it difficult to quantify their activities using Activity Based Funding metrics. The RACP encourages the IHACPA to recognise public health physician responsibilities that interface with public hospitals and are not individual patient procedural in nature, but which bear a cost. Other RACP physician disciplines for inclusion in this conversation are clinical pharmacology and toxicology and occupational and environmental medicine.

NEP indexation methodology

For the review of NEP indexation methodology, the RACP highlights the need for more granular data on the various cost drivers already noted in this submission. This includes the costs of the health workforce in rural, regional and remote areas, including transport, practitioner travel and accommodation costs involved in episodes of care, the additional time and supports needed for priority patient groups with complex needs in various hospital care classifications, costs of innovative models including remote or virtual care arrangement and costs of hospital services provided by sub-specialties that may not have a direct patient-facing role.

Harmonising price

Price harmonisation processes should account for the challenges associated with providing hospital procedures in different geographical locations. Accommodation, travel, transport and additional time requirements for rural, regional or remote patients should be factored into pricing considerations. Harmonisation should also address the differences between physical outreach models and virtual care, both of which support care in place.

Setting the National Efficient Cost (NEC)

NEC indexation methodology

The RACP thanks the IHACPA for considering our feedback from 2022 underlining the need for the NEC to better reflect the ongoing cost pressures in rural, regional and remote hospitals. The RACP reiterates some of the key drivers of cost for NEC:

[9] Australian Influenza Surveillance Reports – 2023 | Australian Government Department of Health and Aged Care
[10] National Notifiable Diseases Surveillance System (NNDSS) fortnightly reports | Australian Government Department of Health and Aged Care
[11] World Health Organization [online] https://www.who.int/europe/news-room/fact-sheets/item/post-covid-19-condition
[12] Parliament of Australia, Sick and tired: Casting a long shadow, Inquiry into Long COVID and Repeated COVID Infections, House of Representatives, Standing Committee on Health, Aged Care and Sport, April 2023 [online]; https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/RB000006/toc_pdf/SickandtiredCastingalongshadow.pdf
[13] RACP, Public Health Physicians: Protecting, Promoting and Improving Health for the Whole Community November 2020 [online]; public-health-physicians-protecting-promoting-and-improving-health-for-the-whole-community.pdf (racp.edu.au)

- Lack of suitably qualified disability support workers and providers that may make discharge from hospital into the community more challenging and may carry higher risk of complications, combined with the additional time and resources required to support discharge from hospital into the community.
- Inflation stemming from and exacerbated by supply chain disruptions in regional and remote areas, compounded by national inflation.
- Increased cost of staff accommodation and relocation costs.

Assurance of cost data

While an Independent Financial Review (IFR) of the National Hospital Cost Data Collection (NHCDC) will not be conducted at this time, the proposed jurisdictional discussions on NHCDC and data quality statements will assist in ensuring adequate alignment with the Australian Hospital Patient Costing Standards (AHPCS). As already indicated, standardising data is essential to gain an accurate and comprehensive view of priced services.

In our 2022 submission to the Pricing Framework, the RACP urged the IHACPA to centre priority patient groups who often require increased care during hospital admission and increased support in the community post-discharge from hospital. The RACP again emphasise that a future IFR should focus on these factors as drivers of cost and funding.

With COVID-19 transmission still present in the community the emergence of Long COVID, and rapid growth in other respiratory infections, these present a considerable population health issue and the RACP again suggests workers compensation claims data, payment and outcome data, and locum placement data should be a focus for data quality assurance.

Future Funding Models

Trialling innovative models of care

The RACP is a strong advocate for innovative models of care that extend beyond hospital settings and leverage current and emerging technologies. Effective integrated care models must include specialists, paediatricans, primary care providers and other health professionals working together to provide improved patient outcomes, reduce hospital admissions and ensure quality and cost-effective use of public hospital settings.

The RACP supports the incorporation of alternate funding models into the current Activity Based Funding system as it has the potential to incentivise the move towards value-based care and a focus on outcomes over volume of services.

As previously advised, the RACP has developed a Model of Chronic Care Management[14] as an example of an innovative service model that bridges primary and specialist care for people with comorbidities at an intermediate level of care to make multidisciplinary team care more accessible and patient-centred. Coordination of services for people with chronic and complex needs has been shown to reduce the incidence of preventable hospital admissions, improve patient health and wellbeing and transitions of care, improve the interface between hospital and community providers and offer additional support to caregivers.[18]

The target population of the RACP model are those with cardiovascular related multi-morbidities at elevated risk of hospitalisation and therefore requiring both a general practitioner and consultant physician to prevent exacerbation of their conditions. It excludes patients who make frequent presentations to the hospital and who are so 'high risk' that no significant improvements can be made in reducing their level of future hospitalisations. Patients meeting risk assessed criteria would have their care delivered and managed by a core multidisciplinary team of clinicians, including those based in hospital settings.

The RACP envisage that this model would be funded by pooling funding from Commonwealth and State governments into funds at the local hospital network area which would be jointly managed by their associated

[14] RACP, Complex care, consultant physicians and better patient outcomes Streamlined complex care in the community October 2019 [online]; c-final-mccm-document.pdf (racp.edu.au)

local hospital district/network (LHD/LHN) and primary health network (PHN), as well as Aboriginal Community Controlled Health Organisations (ACCHOs).

One possible source of funds could be a modest share of current Activity Based Funding of public hospitals contributed by both tiers of government. Other sources that could be considered include current MBS payments for Chronic Disease Management items and practice nurse incentive payments to fund the specialist nurses that may be required in the model. For more information on the model, please see a comprehensive explainer here.

Data for innovative models of care

In informing a methodology for funding innovation care it is important to ensure that data collection is expanded beyond episodes of in-person care to capture information about where and how health services are being delivered.

As in our previous submissions to the Pricing Framework, the RACP continues to stress the need for adequate data collection for virtual care, including telehealth outpatient activity logs and, potentially, data from telehealth solution vendors.

Remote patient monitoring in the home or elsewhere and clinician time reviewing data are other sources of critical data to inform both the design of innovative models of care and the assessment of their costs. Examples of remote monitoring include wearable devices or remote sensors used to check vital signs such as heart rate, blood pressure or oxygen levels from a distance. By transmitting data in real time, remote monitoring allows for early intervention, potentially preventing the need for an emergency department or hospital visit.

'Point of care testing' by physicians and paediatricians, including mobile ultrasound, echocardiograms, and imaging provided by hospitals in the community are examples of Local Health District outreach models reducing inpatient services that require appropriate funding mechanisms. Finally, data on the activities of Local Hospital Network clinical support or medication advisory panels that assure the safety, quality and appropriateness of patient medications must be collected and analysed.

Pricing and funding for safety and quality

The RACP supports the IHACPA clear commitment to reducing sentinel events, hospital acquired complications and unplanned hospital admissions. To aim and fund for safety and quality, all players in the health system must:

- Promote ambulatory care programs in the community, including secondary prevention services post an acute episode.
- Incentivise clinician in-reach and outreach services, especially in rural and remote areas.
- Incentivise hospital-in-the-home programs.
- Incentivise innovative and integrated models of care incorporating technologies, particularly involving telephone, video and remote monitoring devices.

To conclude, the RACP wishes to stress that hospital reform is a component of the much broader national health system reform agenda and as such must be closely aligned with 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.

The RACP thanks the IHACPA for considering our submission and look forward to the opportunity to contribute to the work of the IHACPA further. Please contact the Policy and Advocacy Unit via policy@racp.edu.au regarding any additional information.