Australian Psychological Society

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Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300
Via email: submissions.ihpa@ihpa.gov.au.

Dear Sir/Madam

Re: Non-Admitted Care Costing Study - data collection

The Australian Psychological Society (APS) welcomes the opportunity to provide a brief submission to the Independent Hospital Pricing Authority (IHPA) regarding its Non-Admitted Care Costing Study (the Study).

The APS is the largest professional organisation for psychologists in Australia representing over 24,000 members. A significant proportion of the APS membership work in clinical service units spanning health and mental health and deliver psychological services to Australians who receive public hospital inpatient and outpatient services. It is, therefore, highly appropriate and timely that the APS, submit to this consultation.

The APS has limited its response to the Study questions it deemed the most pertinent to its membership. After consultation with IHPA, the questions requiring response were judged to be the following.

Question 1. What changes to the scope of the Study should be considered?
The APS believes the Study scope is appropriate and no changes are required.

Question 6. What are other ethical issues that should be considered for the Study?
The ethical safeguards proposed to apply in the Study are adequate and appropriate. To ensure adherence to them, however, it will be important to provide compliance monitoring and invest sufficient time to successfully conduct the face-to-face and other requirements of the Study. In the extremely busy non-admitted work environment, any diversions from Activity Based Funding places unnecessary time stress on practitioners, programs and services. To ensure the fidelity of the processes outlined, the potential demands of the Study need to be recognised and accommodated. There will also need to be confidence that the mobile "app" will be secure and user-friendly.

Question 7. Are there any unnecessary data elements on the list in Table 1? Why are they unnecessary?
The data elements listed in Table 1 all appear necessary. There is some potential redundancy in the "did not attend" and "patient present" probes. These could be combined, but the saving that would ensue will be minimal and there may be sound reasons for that separation that are not immediately apparent to the APS.

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Question 8. Are there any data elements that are not on the list in Table 1 that should be included (i.e., features of patients/service events that are likely to impact the cost of the care delivered to a patient)? For what reasons should these be collected in the study?
The data elements listed are comprehensive. Unless it is collected elsewhere, a possible omission relates to the failure to specify the collection of fundamental demographic data (for example, age, gender and postcode). While still ensuring that patients remain unidentifiable, the richness gained from incorporating such data will shed light on non-admitted health activity and is crucial to the development of appropriate costings.

Question 9. What clarifications or enhancements can be made to the definitions and/or values of the proposed data elements in Table 1?
The main issue related to Table 1 stems from its reliance on the associated appendices. [See the response to the next question.]

Question 10.The short list of primary presenting conditions is provided at Appendix A. Does the list capture the range of conditions encountered by each non-admitted clinic type that might be relevant for a patient -level classification of non-admitted care?
The list does not adequately capture the range of conditions encountered by each non-admitted clinic type. There are several issues that require revision.

For instance, there is no recognition in the Appendix of any health psychology-related conditions that might be seen in an outpatient liaison psychiatry setting; for example, obesity or surgery-related phobia preventing an operation. Similarly, there is no recognition of the impact of psychosocial issues (e.g., grief and adjustment disorders and family violence), learning disabilities or the social determinants of health (e.g., housing, malnutrition and family breakdown) on non-admitted health activity.

Appendix A also allocates activities to some professional groupings and not others who are better-placed and more likely to be providers of such activities. To illustrate, substance abuse disorders are listed and identified as a presenting condition that might be addressed by social work. There is, however, no reference to the fact that treatment would be provided by a psychologists. The social work profession has a role to play in the holistic care for people with substance abuse disorders but are unlikely to be the providers of treatment.

It also inappropriately aggregates conditions. For example, personality disorders are categorised with acute stress reaction, adjustment disorder and post traumatic stress disorder under the Tier 2 class/code 19-0056: ”Dissocial personality, borderline, dependent personality disorder, acute stress reaction, adjustment disorder, post traumatic stress disorder”. In standard classificatory approaches to mental illness, these conditions bear no direct relationship to each other and it is unclear why they have been thus aggregated.

Throughout it, there is a strong focus on the physical element(s) of the presenting condition at the expense of the underlying psychological factors involved in that presentation. This omission is important in terms of activity unit costings, given psychological factors typically moderate service demand related to primary physical presenting conditions, especially where they are chronic in nature. This is particularly the case for

patients with burns or paraplegia, but also for conditions such as cardiovascular disease and asthma. Psychological factors need to be better accounted for.

Taken together, and because Table 1 and Appendix A are inter-related, the absence of such information in Appendix A will necessarily compromise the usefulness of Table 1 if it is not addressed. As a result of conversations with IHPA, the APS understands that it is **IHPA's intention to survey sites and professions in more detail in order that this Table is more comprehensively populated. The APS strongly supports this action**, as in its current form, although there is reference to psychology, mental health specialists and neuropsychology, the details relating to such are imprecise and inadequate.

The APS appreciates the opportunity to provide feedback to IHPA. On numerous occasions the APS has emphasised to IHPA the need to better understand the role of the psychology profession in relation to hospital service delivery in order to ensure the accuracy of hospital pricing. The APS reiterates its willingness to work with IHPA to improve this situation. As a key stakeholder, it urges IHPA to seek psychology representation on the Study consortium and other advisory processes and research projects.

I would be pleased to discuss the APS's concerns in more detail and can be contacted on (03) 8662 3375 or at t.mchugh@psychology.org.au for that purpose.

Yours sincerely

Tony McHugh
Policy Officer