Australian Psychological Society

Level 13, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300
F: (03) 9663 6177
psychology.org.au

August 21st 2017

The Secretariat
The Independent Hospital Pricing Authority

Email: submissions.ihpa@ihpa.gov.au

Dear Secretariat staff

Re: The Independent Hospital Pricing Authority *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19*

The Australian Psychological Society (APS) welcomes the opportunity to provide a brief submission to the Independent Hospital Pricing Authority (IHPA) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19 (the Consultation Paper)*. The APS is the largest professional organisation for psychologists in Australia representing over 22,000 members.

A significant proportion of its membership deliver psychological services to Australians who receive public hospital inpatient and outpatient services as members of clinical service units spanning health and mental health. It is, therefore highly appropriate and timely that the APS, as a key professional body in the public health and mental health domains, submit to the consultation.

In making this submission, the APS sought feedback from members who are discipline leaders in general, health, clinical, organisational and neuropsychology within the public hospital sector. Based on their feedback, this brief submission offers the following responses to a subset of the *Consultation Paper* questions that impact upon the delivery of psychology interventions across a range of health and mental health conditions. The APS offers no comment on consultation questions where they are outside its expertise to do so.

The Australian Psychological Society Limited
ABN 23 000 543 788

[Consultation question 4.3] What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups Classification system?

In the operation of the Australian Refined Diagnosis Related Groups Classification system (ARDRGCS) that lies at the heart of the National Efficient Price (NEP), it is critical that the data which underpins it is valid and reliable. From discussions with its members in the public sector, and IHPA itself, the APS understands that the current data collection process for reporting data is, unfortunately, subject to variable compliance in relation to the standards set out in the IHPA Allied Health Activity Hierarchy (IAHAH). It is, for example, aware that some jurisdictions and hospitals report limited psychology data or none at all.

The APS is, therefore, concerned that the data on which psychology prices are calculated is patchy and not representative of the actual activity levels, true delivery costs and the value-for-money contributions psychology makes in the public health settings across Australia. This situation raises the possibility that the existing pricing arrangements relating to psychology are premised on untested assumptions that may create discrepancies between price mechanism and the true value of psychological interventions. The APS is of the view that all hospitals across Australia must conform with the requirements of the system so that more and more accurate data around psychology is available to IHPA and Federal and State Government Funders.

[Consultation question 4.5.1] Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP 18.

Yes, the APS supports the shadow pricing of non-admitted multidisciplinary case conferences. It considers that this has been a significant absence from previous versions of the NEP. It believes that establishing a price mechanism for multidisciplinary team (MDT) case conferences where the patient is not present, would be a patient-centred initiative in the NEP 18 capable of enhancing the quality of patient care across various stages of their interaction with the health system.

The APS is aware that for patients with complex needs, much time is typically spent in case conferences. For that time to not be funded in future arrangements when it has the potential to make a significant contribution to the quality of face-to-face treatment would be a serious, continuing omission. Linking the occurrence of an MDT case conference to follow-up treatment will also provide important data that can test the effectiveness of relationship of treaters and agencies across systems and their contributions to patient wellbeing.

There are other, similar situations, where the Activity Based Funding (ABF) intervention concerned is accompanied by an equal or greater amount of time in non-ABF work that supports that intervention; for example, neuropsychological assessment of patients with complex needs, where there is routinely much liaison, discussion and case management involved. The APS believes that this and all such situations need to be reflected in the NEP 18.

[Consultation question 4.8] What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

The APS welcomes the intention to give increased focus to child and adolescent mental health consumers in version two of the Mental Health Care Classification (AMHCC_v2) noted in the *Consultation Paper*. It is of the view, however, that there are a range of other issues that need to be reflected in the AMHCC_v2.

First, the APS believes that there are strong grounds for an increased focus on a range of other community population groups within the AMHCC_v2. The APS considers it would be beneficial to also include in the focus:

- Older aged people with chronic physical and/or mental health problems
- Those at risk for mental illness because of their membership of groups with known increased risk to mental illness; for example, those occupationally at risk to traumatization, middle-aged, unemployed and "separated men", those from culturally and linguistic community groups (especially refugees and survivors of torture), young people struggling with gender identity issues and those from low socio-economic backgrounds and
- regional, rural and remote Australians.

Although not usually included in an individual's care from the perspective of pricing arrangements, the APS believe it would also be prudent to provide for enhanced interventions for patient families and carers. This is routinely the case in compensable medicine systems (such as worker's compensation, transport accident and victims of crime systems and the schemes operated by the Department of Veterans Affairs) and there is no reason why such interventions - which are known to enhance the efficiency and effectiveness of treatment interventions – should not be included in the AMHCC_v2.

Second, the APS strongly recommends that other psychometric measures other than HONOS, LSP, the Basis 32 and K10 (for example, the Checklist for PTSD and the Hospital Anxiety and Depression Scale) should be considered as outcome measures in public hospital environments. This is because evidence-based psychological treatment requires a focus on patient rated experience and outcomes. It and service utilisation data shows that current case mix funding actually leads to a loss of service continuity for patients with chronic conditions. The United Kingdom National Health Scheme experience, and that of APS members working in public hospitals, shows that quality psychological treatment is the key to reductions in service utilisation and improvements in patient care outcome.

Third, there is a range of mental health conditions for which psychological interventions are the first line, evidence-based form of treatment; for instance, the use of individual and group *Dialectical Behavioural Therapy* for Borderline Personality Disorder, *Cognitive Behavioural Therapy* for Psychosis and the use of *Prolonged Imaginal Exposure* for PTSD. This needs to be reflected in the NEP to ensure that patients are provided with effective treatment that is most suited to their needs and most likely to deliver effective outcomes.

Fourth, there are a range of client groups and conditions that present in public hospital environments other than mental health conditions for which psychological intervention is known to be crucial; for example, effective treatment modules exit for

management of heart disease, diabetes, somatisation disorders and lifestyle related conditions. To expand, cancer is now considered a chronic disease, given the overall five-year survival rate across all cancers has risen to 63%, thereby challenging hospitals to define the level of involvement they have in long term care. There is, for example, a "shared care" model that has been developed between hospitals and GP's which the research evidence supports as effective in the treatment of cancer.

In mental and physical generally, there need to be specialised interventions to be reflected in the NEP, guided by the evidence base and mechanisms. One mechanism for doing so exists in the use of care bundles. The Care Bundle is a tool for examining the application of evidence-based-practice (EBP) to health care. Originally used in the critical care arena, it is defined as a set of clinical interventions which are identified by "Level 1" [1] research evidence as necessary to produce a specific outcome. A Care Bundle refers to treatments for which evidence has been also established or near established. To illustrate, the evidence-base for what works in the treatment of PTSD shows that the Care Bundle for the psychological treatment of PTSD should consist of:

1. Trauma-focussed psychological treatment involving prolonged exposure and
2. Evidence-informed psychopharmacology.

[Consultation question 11.4.1] What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?

Funding models need to follow trends in the development of treatment models and should support research and innovative practice. The APS supports IHPA's acknowledgement that service delivery models need to be dynamic. To date, pricing arrangements have too often tended to stifle treatment initiative and innovation by psychology. Psychology has a long and established history of innovation (e.g., in areas as diverse as the treatment of depression and anxiety, chronic pain and burns) and there is a need for IHPA to examine how to optimise the capacity to innovate. Thus, it could provide increased support for provision of psychosocial and targeted psychological interventions delivered by clinical psychologists to the creation of consultancy based, specialised psychology items in various stages of the AMHCC and the ARDRGCS and NEP.

[Consultation question 11.4 (2)] Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

The APS believes IHPA would do well to considered all value-based care models that will lead to improved patient outcomes. A significant point of difference between what happens now in the health and mental health activities of hospitals will be the inclusion of a greater psychology input into of treatment design and implementation of innovative approaches to treatment.

[1] In its narrowest definition, Level 1 evidence is that obtained from a properly designed and randomised controlled trial – that is, the universally accepted gold standard of the triple-blind, placebo-controlled trial with allocation concealment and complete follow up, relating to a homogeneous patient population and medical condition. A broader definition, such as adopted by the UK National Mental Health Service and the US Preventative Services Task Force, includes meta-analyses and systematic reviews of clinical trials.

[Consultation question 12.6.1] What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

The APS understands that it is not merely the medical status of patients that determines readmission. This is because a range of psycho-social risk factors are also strong determinants of readmission. Among the psychological risks are, of course, the continuation of the stressor/medical condition, prior vulnerability and social and psychological support. While some patients can be assisted effectively in community settings, two limitations to this are immediately apparent. First, they often need intermittent longer term lower level input for which the Better Access to Mental Health Initiative (BAtMHI) is poorly suited. Second few private practice psychologists are well trained to support such patients. There is a gap therefore between the BAtMHI and Hospitals that are not funded for ongoing work with such patients and often see their responsibility ending at inpatient discharge. In public hospitals patients with recent inpatient stays (discharged within the previous 3 months) can be eligible for clinical health psychology input on an outpatient basis.

The APS believes this is an important initiative that needs to be supported by the creation of a pricing mechanism that makes this a nationwide option in business as normal. Beyond this particular example, however, the APS believes that the ARDRGCS and NEP need to include pricing structures that influence hospitals to invest more in follow-up to avoid re-admissions and sentinel events that occur pre or post-discharge. It believes that psychology has a crucial role to play in this. It is important to note that such a role this should not be seen as the sole responsibility of mental health services, where psychological or psychiatric issues arise during or post an episode of primary care. This is because, although there is currently no price mechanism for primary care funding such mental health interventions, it is important that provision be made for its capacity to do so where warranted.

Mechanisms for identifying patients at most at risk for readmission should include ratings in a range of psychological risk indicators as measure by clinical judgment or scores of agreed metrics (such as those already mandated for use as part of the stages of mental health treatment or suggested within this submission at question 4.8 above). Adoption of a trouble shooting tool or algorithm cable of taking into account case complexity (e.g., as demonstrated by multiple physical and psychological comorbidities) and the e impact of substance use on readmission rates is much needed.

To minimise both patient churn and non-efficient approaches to treatment, it is important that pricing mechanisms and incentives are introduced which militate against gaming, while delivering effective patient centred treatments and courses of care which make a material difference to the health of patients. This could be done by the introduction of targeted, blended program budgeting and specific pricing mechanisms for innovative evidence-based practice - for example, that support the establishment of strengthened relationships between the public health facilities and the non-government and private sectors which may pick up care post discharge from public hospital by payment for effective linkages.

[Consultation question 12.6.3] Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

Yes, the APS supports the use of the described assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions. It also emphasises the need for equity and access to treatments and courses of care to all Australians regardless of SES, membership of community groups or geographical cation (as implied in chapter two of the *Consultation Paper* and the ongoing need for all health systems to be patient-centred and properly governed in terms of their effective use public funds. It believes that use of appropriately identified and priced psychology will be important.

Other comments

Members have made it clear to the APS in their discussions around the *Consultation Paper* that they are deeply concerned about the lack of benchmarks for psychology in public health and what constitutes reasonable ABF expectations for psychologists working in such settings; for example, in terms of the number of patients seen and the time spent directly and indirectly in doing so. In making this submission, the APS foreshadows its wish that it and IHPA's might better engage in future to ensure an adequate and sustainable pricing and ABF model for psychology.

The APS appreciates the opportunity to submit to this consultation. This submission is summary in nature and the APS would be very pleased to elaborate on any matters raised within it. I may be contacted for this purpose on (03) 8662 3375 or at t.mchugh@psychology.org.au.

Yours sincerely

Tony McHugh

Manager - Professional Practice
Public Sector, NGOs & Schools