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RACP Submission to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21

July 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health 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.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) regarding its Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2020-21 ('Consultation Paper').

The submission will focus on the following issues identified in the Consultation Paper:

- The pricing guidelines
- Additional considerations on pricing for teaching, training and research
- Adjustments for 'legitimate and unavoidable' cost variations
- Access to the National Benchmarking Portal
- Adjustments to the National Efficient Costs model for small rural hospitals
- Individual Healthcare Identifiers
- Patient Reported Outcome Measures
- Bundled payments and other alternative funding models
- Funding approach to Hospital Acquired Complications

Pricing guidelines

The RACP supports the existing guidelines and supports the proposed addition on 'promoting value' as a means of capturing the need for pricing models to support value in hospital and health services. We note that the guidelines with this proposed addition now encompass the three dimensions of health system performance as enunciated in the so-called 'Triple Aim' of:[1]

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations and
- Reducing the per capita cost of health care.

However, if the aim of pricing guidelines is to comprehensively capture all relevant dimensions of health system performance, we would like to direct IHPA's attention to recommendations to expand this Triple Aim to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.[2] As explained by its proponents, enhancing the work life and general well being of health care providers also has benefits for patient care, as their review of the evidence demonstrates that physician and care team burnout is associated with lower patient satisfaction, poorer health outcomes, and potentially increased healthcare costs. A more recent meta-analysis of the relationship between physician burnout and patient safety, professionalism and patient satisfaction covering 47 studies concluded that physician burnout was associated with an increased risk of patient safety incidents, poorer quality of care due to low professionalism and reduced patient satisfaction.[3] In this meta-analysis, burnout was defined as 'a response to prolonged exposure to occupational stress encompassing feelings of emotional exhaustion, depersonalization, and reduced professional efficacy'.

The incorporation of a principle reflecting a 'fourth dimension' of health system performance identified with physician well-being is therefore justified with the implication that pricing should sufficiently fund hospitals to enable staffing at levels which do not result in unsafe hours and unnecessary stress.

Additional considerations for pricing teaching, training and research

The RACP notes that IHPA's progress with pricing hospital services to take account of teaching, training and research (TTR) has stalled except for where teaching and training is delivered in conjunction with patient care such as ward rounds. Other forms of TTR are currently block funded. This may have important implications for some services delivered by our Fellows such as services in public rheumatology clinics where TTR is often intertwined with clinical (but not necessarily patient facing) time. A further complication noted is that different

[1] Institute for Healthcare Improvement (IHI) 2019, The IHI Triple Aim.

[2] Bodenheimer, T & Sinsky, C 2014, 'From Triple to Quadruple Aim: Care of the patient requires care of the provider', Ann Fam Med, vol. 12, iss. 6, pp. 573-576

[3] Panagioti M, Geraghty K, Johnson J, et al. Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis. JAMA Intern Med. Published online September 04, 2018178(10):1317–1331

States will also apply different funding models for the share of activity-based funding that they contribute which will lead to TTR being treated differently (as a form of clinical time) across different jurisdictions. Ideally, to ensure nationally equitable funding for TTR, the different approaches by each State should also be taken into account in the National Efficient Price.

Adjustments for 'legitimate and unavoidable' cost variations

The RACP recommends that IHPA investigate whether patients with behavioural issues secondary to cognitive impairment may incur additional costs which are not currently captured within typical classifications even after taking into account medical complexity. These patients frequently require special nursing services and may require additional resources in terms of security as well as having prolonged length of stay.

Patient frailty is another area that deserves further investigation by IHPA to ensure that all relevant costs of care associated with frailty are accounted for. Frail older people have complex needs not easily categorised that may result in variations in expected costs. These are often social in nature or are dependent on the hospital being able to access services funded by or provided by a third party. This is the case in aged care services and in NDIS-funded services where the availability of services to support patients after discharge is limited or non-existent. This in turn leads to extra costs having to be borne by the treating hospital, either in increased length of stay or the need to provide services the hospital would not otherwise provide. Because the availability of services varies from area to area, costs may be different for one hospital compared to another.

In previous Pricing Frameworks IHPA has introduced a 'Treatment Remoteness Adjustment' and an 'Indigenous Adjustment' to provide for additional loadings to account for higher costs of care for acute patient episodes in these particular cases. This will enhance equity in funding the delivery of hospital services, including but not restricted to services to Indigenous communities. On top of these improvements, the RACP recommends that IHPA investigate an adjustment for patients from culturally and linguistically diverse backgrounds.

Other suggestions for adjustments that could be explored include adjustments for multidisciplinary team involvement and the inability to be discharged directly to home (including need for rehabilitation, need for permanent care, homelessness, and mental health issues).

Access to the National Benchmarking Portal

The RACP is generally supportive of the proposal to allow access to the NBP to be publicly available in future years beyond its current availability which is to state and territory health departments and/or all public hospital staff (depending on the particular state or territory in question). There would be benefits in both allowing equal access to the data contained in the NBP regardless of state/territory and in expanding access to this data to a wider audience such as academics and health policy researchers Service providers can also use the information to better assess their own performance and undertake benchmarking. The main issue however is how patient confidentiality will be maintained. Information held by public administration bodies has been notorious in its propensity to be leaked/hacked or in some other way compromised. Another important caveat to this support aside from appropriate privacy protections is to ensure that the data on individual hospitals is appropriately risk-adjusted to take account of the hospital's catchment area which may have impacts on costs, activity and complication rates such as the complexity of patients served. Where such adjustments cannot be made it is important to inset suitable caveats about the comparability of data between individual hospitals. At the very least, full access to data in the NBP could be phased in by first allowing access to not for profit organisations and academic researchers.

National Efficient Costs model

In its submission to the 2019-20 Pricing Framework the RACP supported the greater flexibility in funding small rural hospitals associated with a 'fixed plus variable' model where each hospital receives a fixed funding amount. We therefore welcome IHPA's decision to introduce this approach and have no further comments at this point in time, and look forward to further evaluations of how this approach works in practice.

Individual Healthcare Identifiers

As the Consultation Paper notes, the Individual Healthcare Identifier (IHI) is an existing personal identifier that was introduced to support the My Health Record system. The use of IHIs should therefore be seen in the context of increasing opportunities to enhance physician and hospital involvement in digital health, which the RACP is strongly supportive of. IHIs will assist in "marrying" up patients' records across sites and allow for easier access to important clinical information which in turn will enhance patient care and management. Thus the RACP is supportive of measures to incentivise use of IHIs.

Patient Reported Outcome Measures

The institution of Patient Reported Outcome Measures (PROMs) is seen as a move towards more patient centred care. A recent review commissioned by the Australian Commission on Safety and Quality in Healthcare[4] found that the evidence is strongest for their use in understanding clinical practice variation insofar as they can help in evaluating the relative effectiveness of different treatments and interventions. There is also good evidence that they can enhance patient-clinician interaction processes. There is however so far no evidence of their impacts in improving individual health status outcomes. The review also found that few Australian clinical registries have so far included PROMs in their measures. Thus there is scope to further expand the collection of PROMs data and also ensuring PROMs data includes data from specialist outpatient clinics.

The expansion of PROM use in clinical registries provides the ideal opportunity to develop a national PROM collection, thereby increasing the prospect of ready uptake by clinical services sooner rather than later. Therefore, the RACP supports efforts to develop a national PROM collection as long as it does not also detract from and divert focus from the equally important and difficult task of collecting robust and objective clinical outcome measures. Ultimately this work should aim towards embedding PROMs and CQRs in electronic medical records (EMRs).

Bundled payments and other alternative funding models

A recent review of the bundled payments approach as applied to stroke care identified the following reasons why stroke care might be suited to a bundled payment approach:[5]

> *… stroke is often characterized by a hyper acute care stage followed by an episode of inpatient care before transitioning into skilled nursing home or rehabilitation*

The RACP therefore suggests that other procedures which involve such transitions across different modalities of healthcare may be suitable candidates for trialling a bundled payment approach. For instance we note that spine surgery[6] and breast cancer care[7] seems to be other areas of medical practice which has been trialled with bundled payments.

More generally the RACP also welcomes IHPA's continued investigation into alternative funding models because there is an urgent need to reconfigure health services to address the increasing proportion of the community that is living with multiple chronic conditions (i.e. multi-morbidities) and these patients are best addressed under alternatives to hospital episode based funding.[8] [9] This is because care for chronic

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[4] Williams K, Sansoni J, Morris D, Grootemaat P and Thompson C, Patient-reported outcome measures: Literature review. Sydney: ACSQHC; 2016.

[5] Matchar DB, Nguyen HV, Tian Y. Bundled Payment and Care of Acute Stroke: What Does it Take to Make it Work? Stroke. 2015 May;46(5):1414-21.

[6] Dietz N, Sharma M, Alhourani A, et al. Bundled Payment Models in Spine Surgery: Current Challenges and Opportunities, a Systematic Review. World Neurosurg. 2019 Mar;123:177-183.

[7] Wang CJ, Cheng SH, Wu JY, et al. Association of a Bundled-Payment Program With Cost and Outcomes in Full-Cycle Breast Cancer Care. JAMA Oncol. 2017 Mar 1;3(3):327-334.

[8] Australian Institute of Health and Welfare. Chronic Disease Overview. Canberra: AIHW; 2018: https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview

[9] Harrison, C., Henderson, J., Miller, G. and Britt, H., 2016. The prevalence of complex multimorbidity in Australia. *Australian and New Zealand journal of public health*, *40*(3), pp.239-244.

conditions cannot be confined to one part of the health sector – these increasingly prevalent conditions often require care at various times at each of the primary, secondary and tertiary sectors. Better communication and interaction between practitioners across these sectors will benefit both the health care providers and patients.[10] The RACP has therefore proposed in its Australian Government Election Statement 2019[11] that a small share of current Activity Based Funding could be redirected (as per the proposal of the Productivity Commission) [12] to fund a model of care for patients with multi-morbidities. Each patient enrolled under this model would have access to a multidisciplinary team of healthcare service providers including a general practitioner, consultant physician, specialist nurse and allied health and these healthcare providers would be funded on what is essentially a capitation basis for outpatient services provided to patients being treated specifically for their chronic multi-morbidities. The RACP is currently undertaking final consultations with external stakeholders to refine its proposed model of care.

Funding approach to Hospital Acquired Complications

The RACP recommends that in implementing the funding approach to Hospital Acquired Complications that IHPA ensure that any potential unintended consequences of this approach are closely monitored and addressed, particularly in those cases where the complication is not easily codeable or easily identifiable.

Examples of unintended consequences could include:

- Reducing payment for delirium resulting in reduced reporting of delirium.
- Reducing payment for falls resulting in measures to prevent falls which are not cost effective overall.
- Reducing payment for aspiration pneumonia resulting in aspiration pneumonias being reclassified as hospital acquired pneumonias or “pneumonia not otherwise specified”.

The RACP notes that some of our members think that the new funding approach is still too divorced from the clinicians working in public hospitals to have much of an impact. It is recommended that measures be considered to bridge this divide – for instance by using the data collected for effective benchmarking rather than just as a means to develop funding penalties.

[10] Sampson, R., Barbour, R. and Wilson, P., 2016. The relationship between GPs and hospital consultants and the implications for patient care: a qualitative study. BMC Family Practice, 17(1), p.45.

[11] https://www.racp.edu.au/docs/default-source/advocacy-library/racp-australian-government-election-statement-2019.pdf?sfvrsn=90c7191a_4

[12] Productivity Commission 2018, Shifting the Dial: 5-year productivity review.