



**RACP**  
**Specialists. Together**  
EDUCATE ADVOCATE INNOVATE

**RACP Submission to Consultation Paper  
on the Pricing Framework for Australian  
Public Hospital Services**

**2021–22**

October 2020

## **About The Royal Australasian College of Physicians (RACP)**

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 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.

## 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 2021-22 ('Consultation Paper').

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

- Impact of COVID-19
- Adjusting the national efficient price
- Alternate funding models

## Impact of COVID-19

While COVID-19 has resulted in reduced presentations in many categories of unplanned presentation, there is anecdotal but widespread physician belief that there has been reduced patient access to rural hospital specialist services due to its impacts, particularly on cohorts already experiencing vulnerability in terms of access to specialist care in public hospitals.<sup>1</sup>

Feedback that we have received from our practising Fellows suggests that in the short term, the following COVID-19 protocols will be likely to push up per patient unit costs:

- Increased personal protective equipment (PPE) use
- Increased use of isolation facilities in hospitals for patients with or suspected of having COVID-19
- Repurposing of existing hospital space for creation of makeshift isolation accommodation in general wards
- Increased utilisation of both PCR and rapid COVID-19 tests
- Increased use of other diagnostics to exclude COVID-19 complications or make positive alternative diagnoses

In the short and long term, we would also expect total health service costs to increase due to the following COVID-19 related factors:

- staff contingency models such as surge capacity to ensure business continuity e.g. for frontline health professionals. At the same time this is happening, there will be health professionals with possible COVID-19 exposure who will have to take time off (possibly at the same time in some areas), therefore reducing the available workforce
- potentially higher staff costs due to the need to perform surgeries after hours and on weekends to manage backlogs
- Increased training required to ensure frontline health professionals are practice ready earlier than normal given the above and potential for reduced staff (for some of the reasons already discussed)
- addressing the health needs of vulnerable and complex patients who had cancelled appointments at the start of the outbreak who may now suffer an exacerbation of their conditions and that require more intensive attention and treatment
- increased transport costs due to reduced patient capacity at rural public health services due to isolation requirements for suspected/probable/confirmed COVID-19 patients
- increased community accommodation costs for patients fit for community isolation but without alternative means of safe isolation e.g. Indigenous patients from remote communities in Queensland and WA who cannot safely isolate or quarantine in their communities while awaiting test results or completion of quarantine period. For instance, according to feedback provided by one of our Fellows practising in the Northern Territory, there was a significant increase in hospital length of stay during the period when biosecurity laws were introduced impacting on patients from remote communities. These patients were only allowed to return to their communities without going into quarantine for 14 days if they remained in hospital and then went directly onto their transport home. This may become a recurring issue if a second wave causes biosecurity laws to be enforced again.

### ***Some additional considerations with regard to outpatient services***

---

<sup>1</sup> Written feedback provided by RACP members.

With respect to outpatient services funded by ABF we note that service delivery since the start of the outbreak is likely to have changed dramatically and these changes may differ in different locations. In particular, we expect some services to face challenges due to changing patient appointments (noting the likelihood of cancellations at the start of the pandemic followed by 'catch up' attempts since restrictions have been loosened). This means recorded activity levels for these services will potentially be more unreliable as administrative staff have had to adapt to sudden changes in appointment type. Thus, IHPA should not be relying on recorded activity data over the pandemic at face value for setting funding for future hospital activity especially in terms of using it to reduce commissioned activity in future years.

We note that some specialist services such as genetics services which are for the most part outpatient based have moved to primarily telehealth-based care. This brings with it its own set of issues as services as a matter of new policy have had to any face to face appointments which are classified as non-urgent, even where patients are reluctant to use telehealth.

## **Conclusions**

In summary, the impacts of COVID-19 have laid bare some of the vulnerabilities in the current funding model. Insofar as COVID-19 may result in significant volatility in the share of variable hospital costs (due to reductions in patient care activities across the spectrum of care during outbreak periods followed by short term upswings in activity during periods of reduced transmission and loosening of restrictions), the current significant weighting of hospital funding towards variable costs (with more than 90% of funding going towards variable costs) is likely to increase the difficulties faced by our health services in managing their costs with the funding received. This is more so as a reduction in face to face patient care activities and their partial substitution with alternatives which may require a greater call on fixed costs (e.g. telehealth and digital health infrastructure) may be one legacy of the COVID-19 outbreak. This volatility will add to the difficulties already faced by health services in rural and regional areas and other areas that serve people of lower socio-economic status.

In light of these factors, it may be worthwhile for IHPA to consider rebalancing the fixed cost to variable cost weighting that currently applies so that there is a greater 'buffer' in the form of a larger fixed cost component for hospital funding. This would be of benefit in allowing all hospital types including rural and remote hospitals to better manage the recovery of their costs. For instance, the additional loading that currently applies to very remote hospitals and goes towards the fixed rather than the variable component of their costs would be more effective if the fixed cost component allocated was larger to start with.

## **Adjusting the national efficient price**

### ***Patient transport in rural areas***

We support the IHPA's proposal for an adjustment in the national efficient price to reflect patient transport in rural areas, including medical transfers and other inter-service transports in rural areas. Rural patient transport is often unavailable for transport of patients to specialist public hospital physicians for definitive care and this is only likely to be amplified under COVID-19 as demand for such transportation increases. We also recommend that the adjustment for patient transport should incorporate the cost of support for escorts to accompany patients from their rural homes to specialist care. Rural patients facing hospitalisation alone are disadvantaged in every aspect of hospitalisation. The provision of patient escorts would improve comfort, communication, and adherence to care including reducing discharge against medical advice, hence addressing the psychosocial aspects of medical care which can be as important as the biomedical aspects.

While there are State and Territory based Patient Assisted Travel Schemes, a review of these schemes has revealed their non-uniform principles of eligibility and non-uniform and inadequate travel and accommodation benefits<sup>2</sup>. It is essential that such costs are captured to ensuring funding of patient transport services so that

---

<sup>2</sup> Bachman et al. Patient Assisted Travel Schemes: are they actually assisting rural Australians? [http://www.ruralhealth.org.au/14nrhc/sites/default/files/PosterPaper\\_Irwin%2C%20Rebecca.pdf](http://www.ruralhealth.org.au/14nrhc/sites/default/files/PosterPaper_Irwin%2C%20Rebecca.pdf), last accessed October 12, 2020.

rural and remote patients may access clinically appropriate specialist care in a timely manner, whether ambulatory or inpatient.

Introducing the proposed adjustment will also enhance transparency of such funding, ensuring that funding allocated for patient transport is used for that purpose as the alternative is that unused funds (for patient transport) are returned to individual Hospital and Health Services (HHSs) general revenue, which may disincentivise HHSs from supporting patient applications for the subsidy.

We note that rural Australians continue to suffer excess morbidity from almost every cause<sup>3</sup> so the sustainable long term solution to this is to ensure that adjustments to the NEP for rurality provide sufficient incentives for doctors to move to rural areas.

### **Other possible adjustments**

We recommend that IHPA consider some weighting be considered based on a broader consideration of measures of social determinants of health such as socioeconomic status (SES). This weighting could operate the same way a rural weighting currently does. While acknowledging that there are already weightings for DRG complexity which may capture some of the special challenges of low SES patients, patients with high need with regard to SES may still not be sufficiently well captured by DRG complexity.

We also note feedback that we have received from our clinical genetics members that the NEP for genetics services does not cover the cost of services currently, in part due to the high cost of genetic testing, and in part due to the complex and lengthy nature of the consultation. As geneticists often provide advice and care through multidisciplinary and cross-LHD teams due to the rare nature of genetic disorder, their activities may not be adequately captured in existing ABF models. We recommend that these potential impacts also be investigated for other services which are part of multidisciplinary and cross LHD teams. Our clinical geneticist members have also highlighted that their services may be underfunded because they have direct contact with only a few family members while providing tailored advice for many members of the family, leading to a low number of Non Admitted Patients Occasion of Service (NAPOOS) recorded per family. This can lead to a skewed assessment of the cost of service in general cost centres for genetic services.

Finally, as IHPA is taking the laudable approach of reviewing adjustments for patient transport in rural areas, we recommend that it broaden its investigations to consider the extent to which the NEP should incorporate a separate adjustment for disability so that it can be sufficiently weighted to overcome the systemic barriers to the provision of healthcare that may be faced by people with disabilities (regardless of location or specific diagnosis).

These systemic barriers are wide and well documented, and include physical, policy, procedural and attitudinal barriers in hospitals.<sup>4</sup> Some specific examples include

- the need for special transportation to the hospital (and potentially within the hospital),
- accommodations that may need to be made to hospital infrastructure,
- provision of carers and assistants to ensure that their needs, wants and different experiences are respected.
- Additional time taken on behalf of physicians and other medical professionals to work in partnership with these patients to ensure that care is tailored and equitable

While people with disabilities may have other characteristics which are already covered by some of the existing adjustments (e.g. need for dialysis, remoteness, paediatric, ICU) it is important for IHPA, given that Fairness is one of the overarching Pricing Guidelines, to investigate whether systemic cost factors associated with disability may require a separate NEP adjustment for this group of patients so that they have equitable access to public healthcare.

## **Alternate funding models**

---

<sup>3</sup> AIHW, Rural and remote health <https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health>, last accessed October 12, 2020.

<sup>4</sup> Lagu, T., Iezzoni, L.I. and Lindenauer, P.K., 2014. The axes of access—improving care for patients with disabilities. *The New England journal of medicine*, 370(19), 1847-1851.

COVID-19 has shed light on structural issues in state/federal government healthcare arrangements, for example, funding, workforce provision and quality assurance of aged care facilities and medicines availability. These include structural issues which inhibit better management of patients with chronic disease, which takes on renewed significance given the relationship between chronic disease and increased risk for severe illness from COVID-19.

Programs which promote better linkages between state-funded-public-hospital-specialist-physicians and federally-funded-community-based-healthcare-providers (including general practitioners) to improve prevention of avoidable complications and hospitalisations are a step in the right direction.

While capitated funding to hospitals (such as that provided by the HealthLinks program being evaluated by IHPA) can be one possible alternate funding approach, this approach must be contingent upon adherence to standardised, evidence-based discharge care pathways and other evidence-based guidelines to mitigate the cost cutting incentives that it introduces. Without such mitigation, capitation funding can lead to unjustified cost cutting in a variety of contexts. For instance csDMARDs (conventional synthetic disease-modifying antirheumatic drugs) require significantly less time and effort compared to commencing and continuing patients on b/tsDMARDs (biological and targeted synthetic disease-modifying antirheumatic drugs) so funding systems such as capitation which put the risks of managing costs on providers may incentivise them to prescribe the former over the latter even when this is unjustified.<sup>5</sup>

Programs or proposals for innovative models of care which we would like to draw attention to are:

- The [RACP Model of Chronic Care Management](#). This is a proposal for the development of an integrated model to recruit, manage and treat patients with chronic multi-morbidities, with two pathways, one from primary care and another from secondary/tertiary care. 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 or alternatively they would collect the payments themselves if they are private practitioners in the community (we note that specialist physicians typically can be either or both). This model would be funded by pooling funding from Commonwealth and State governments into funds at the local hospital network area with one possible source of funds being a modest share of current Activity Based Funding of public hospitals contributed by both tiers of government.
- An Australian pilot study in Melbourne involving 896 families of a model where paediatricians are embedded into GP clinics found that this approach reduced emergency department referrals and unnecessary prescriptions while boosting GPs' confidence in treating common childhood conditions.<sup>6</sup> Under this model, because there is no Medicare item number that allows a paediatrician and a GP to bill for a co-consultation session, the study paediatricians were salaried by the Royal Children's Hospital and the GPs billed Medicare using standard item numbers.
- For the last decade, the Mater Hospital Group in Queensland have had an emergency department with occupational and environmental medicine oversight providing services to hospital employees. This has resulted in the return to work rates of employees in the Mater group who made worker compensation related claims being better than other hospital groups in Queensland, with around 80% of injured Mater hospital employees being able to immediately return to work following their assessment and treatment compared to the industry average of around 30% in the 2013-14 financial year when OEM oversight first commenced (on average Mater employees who did not opt for the in-house OEM service took 2-3 days sick leave<sup>7</sup>. Even the most recent data from 2017-18 found that the significant difference between Mater (more than 75% immediate return to work) and the industry average (under 50%) persisting. This approach has also resulted in a reduction in worker compensation premiums for the Mater Group. While this is an approach being adopted for hospital employees rather than the general population, its lessons may suggest the value of embedding the services of some specialists not typically seen as hospital based into general models of care.

---

<sup>5</sup> Written feedback provided by Australian Rheumatology Association.

<sup>6</sup> Hiscock H, O Loughlin R, Pelly R, Laird C, Holman J, Dalziel K, Lei S, Boyle D, Freed G. Strengthening care for children: pilot of an integrated general practitioner-paediatrician model of primary care in Victoria, Australia. *Aust Health Rev.* 2020 Aug;44(4):569-575. doi: 10.1071/AH19177. PMID: 32045563.

<sup>7</sup> Written feedback provided by AFOEM member. More details are available on request.

In determining which patient cohorts or Adjacent Diagnoses Related Groups (ADRGs) may be amenable to certain new funding models, we recommend that IHPA take account of the following considerations:

- As noted previously, funding models should be able to accommodate multidisciplinary teams and specialised Supra-LHD services, and time for administrative workload by physicians to manage the more complex care pathways.
- The need for a sound evidence base for the prevention of disease complications. For instance we note that the results of numerous US Centers for Medicare and Medicaid Services (CMS) pilots already undertaken be carefully interpreted as some of the results to date, particularly with respect to non-payment policies have been disappointing<sup>8</sup> (we note that these consideration also relevant to feedback IHPA is seeking on pricing for safety and quality).
- There is likely to be heterogeneity in pilot site outcomes for similar kinds of funding models i.e. with some demonstrating success and some not but this may be because these studies are not fully able to control for organisational factors such as health service technical capability; physician and managerial 'champions'. We therefore urge caution in interpreting the results of these studies. Such idiosyncratic, site-specific factors will need to be addressed in funding design.
- Changes in remuneration due to **changes in performance** rather than by levels of performance should be considered as part of alternate funding models including capitation funding as this provides incentives for any hospital to participate and invest in improving health outcomes for patients without dulling incentives for 'top' performers to rest on their laurels.
- Alternate funding models should not just be about short-term 'carrots' and 'sticks' but be about creating a learning health system where the top performing hospital sites with skilled clinician researchers can share qualitative lessons across the system to improve all-hospital performance.
- Pertinent to the previous point, one of the means of creating such a learning environment is by better exploiting digital health tools which can facilitate robust program evaluation, thus allowing continuous improvement through 'tinkering' in the design of whatever new funding models are identified.
- It is important to pay heed to the lessons from behavioural science research in the area of health service innovation and in particular the implications of behavioural economics for funding design as some findings suggest ways in which the impacts of funding incentives can be augmented independent of the size of the reward (or penalty) being set.<sup>9</sup> However one of the lessons from this field is that in some cases, financial incentives can have perverse or counter-intuitive effects (again this is also of potential relevance for the designing of pricing for safety and quality). For instance, there is some evidence that extrinsic motivators, such as monetary incentives or punishments, can undermine intrinsic motivation<sup>10</sup>.
- The role of the clinical academic to facilitate translation into practice should be supported as this enables cutting edge research including patient flow and qualitative work to be integrated into care; This has been shown to improve care, reducing wastage, improving multidisciplinary care and reducing overall hospital costs in contrast to normal practice such as introducing new systems, drugs and devices which tend to increase hospital costs in the long run notwithstanding their benefits.
- We note that the operation of home visiting services provided by a multidisciplinary team, which is of particular relevance to care of elderly patients (but may also apply to others) is currently not possible under Tier 2 Non-admitted services. We recommend that in its investigation of innovative models of care that IHPA consider the funding of such services on a pilot basis and use this as an opportunity to consider the case for broader funding of such models which would occupy a space between admitted care and Tier 2 non admitted care services.

---

<sup>8</sup> Schuller K, Probst J, Hardin J, Bennett K, Martin A. Initial impact of Medicare's nonpayment policy on catheter-associated urinary tract infections by hospital characteristics. *Health Policy*. 2014 Apr;115(2-3):165-71. doi: 10.1016/j.healthpol.2013.11.013. Epub 2013 Dec 5. PMID: 24361201.

<sup>9</sup> Emanuel EJ, Ubel PA, Kessler JB, Meyer G, Muller RW, Navathe AS, Patel P, Pearl R, Rosenthal MB, Sacks L, Sen AP, Sherman P, Volpp KG. Using Behavioral Economics to Design Physician Incentives That Deliver High-Value Care. *Ann Intern Med*. 2016 Jan 19;164(2):114-9. doi: 10.7326/M15-1330. Epub 2015 Nov 24. PMID: 26595370.

<sup>10</sup> Frey, B.S. and Jegen, R. (2001) "Motivation Crowding Theory" *Journal of Economic Surveys* 15(5):589–611