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AMA submission on the Pricing Framework for Australian Public Hospital Services 2022-23

The Independent Hospital Pricing Authority
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Thank you for the opportunity to comment on the 2022-23 Public Hospital Pricing Framework. Our comments are outlined below and organised under the chapter headings used in the consultation paper.

Accounting for COVID-19 in public hospital pricing

The AMA is very pleased markers have been added to the data sets to identify the cost impacts of COVID-19 related activity in the 2022-23 National Efficient Price (NEP). If PPE costs are not already captured as a direct cost of COVID-19, then it should be taken into account.

COVID-19 infected patients are not the only COVID-19 cost impact on public hospitals. The COVID-19 response also suspended all elective surgeries other than the most urgent category, during the first quarter of 2020. Patients who had their elective surgery suspended are at greater risk of developing complications when they are admitted for surgery, are more likely to need a longer length of admission, higher treatment costs and worse patient outcomes[1]. The elective surgery suspension was not the fault of the hospital or the direct result of the way in which the state or territory governments manage their hospital system. Suspended elective surgeries during the first quarter of 2020 should be eligible for the Commonwealth agreement and the 50:50 COVID-19 cost share arrangements.

Patients with 'long COVID-19' should be tracked in public hospital data so that damage from long-term effects of COVID-19 on heart tissue or other organs can be included in the COVID-19 price adjustments in the future. Medical colleges are probably the most authoritative source of advice on the incidence and risks of 'long COVID-19' and other COVID-related complications.

AMA would also expect all patient complications and readmissions directly due to COVID-19 delays in patient care, to be exempt from the financial penalties that would otherwise apply

[1] Drew B Richardson, 'The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay,' Medical Journal of Australia 177: 9 (November 2002), 492–495; Peter C Sprivulis, et al. 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments,' Medical Journal of Australia 184:5 (March 2006), 208–212; Drew B Richardson, 'Increase in patient mortality at 10 days associated with emergency department overcrowding,' Medical Journal of Australia 184:5 (March 2006), 213–216.

under the safety and quality framework. Identifying these patients in the data should be relatively straight forward by referring to the waitlist data in the first quarter of 2020.

Price harmonisation across care settings

The AMA does not oppose price harmonisation to encourage best practice care in the most appropriate site of care, providing the cost weights over time do not financially penalise public hospitals if clinicians consider admitted care is necessary for because of patient age, fragility or comorbidities. The cost weights applied in a non-admitted setting should not perversely incentive a hospital to treat a patient in a non-admitted setting if the patient should be admitted. The implementation of price-harmonisation across settings must not leave public hospital patients worse off.

Non admitted care Classification

The AMA welcomes IHPA's work to develop a new non-admitted care classification to measure patient complexity and cost of care provided in a non-admitted setting. Jurisdictions are best placed to provide feedback on their readiness to participate in a costing study to inform this work.

Teaching and Training

The AMA recognises the important role public hospitals play in the training of our skilled healthcare workforce, and it welcomes IHPA's efforts to continue to investigate alternative models to block funding until the Australian Teaching and Training Classification can be enabled.

Next steps for alternate funding models

The AMA welcomes increased funding flexibility that allows public hospitals to trial new models to flex the type, place and mix of admitted/non admitted patient care to deliver optimum patient outcomes. This new flexibility will likely work well for many public hospital patients but not all.

Patients with complex mental illness frequently end up requiring an admission because there are too few community-based mental health programmes that provide the long term clinical and social supports these patients need to manage their disease(s). Rosenberg et al[2] report seriously unwell mental health patients need a mix of clinical care, addiction services, legal support, social inclusion support and housing to manage their disease[3]. Many of the services are not 'in-scope' for Commonwealth ABF funding contributions. Between 2013-14 to 2018-19 mental health admissions increased by 5 per cent each year – the fastest growing admission rate of all conditions that required an admission in this five-year period.

AMA has similar reservations about the extent to which flexible combinations of admitted and non-admitted care will reduce demand for hospital beds for frail elderly patients, disability patients, socially disadvantaged patients, alcoholics, and Aboriginal patients who are difficult to safely discharge for appropriate follow up non-admitted care because they frequently don't have secure housing or a safe discharge destination.

[2] Rosenberg S. Lawrence P. and Hickie I (2021) MJA Insight, Issue 23, June 2021 "Who are the 'missing middle' of mental healthcare?"

The AMA would welcome clarification on whether flexible ABF funding allows jurisdictions to collaborate with managers of other government(s) funded services to expand new models of multi-disciplinary care to better meet the needs of complex patient cohorts.

The AMA agrees states and territories are best placed to nominate their own models of care to trial under innovative service models.

The transition to Value based healthcare

The current relentless demand pressure that has hit public hospitals (and not caused by influenza) has thrown many hospitals across different jurisdictions into crisis. While-ever demand exceeds available staffed public hospital ward beds it is hard to see how States and Territories can allocate precious resources to build the capacity to develop and implement innovative models of care.

Even then, a shift to innovative models of care will only be the first step towards empowering public hospitals to deliver value-based healthcare. Building the internal hospital/state capacity for increased data collection and data analysis to enable jurisdictions to measure patient outcomes, relative to service costs, is complex and expensive. A key insight from the Australian value- based cancer care project is that clinicians leading value-based health care, need access to real time patient data to monitor patient outcomes across service settings. No additional funding was allocated in the Addendum to share these costs with jurisdictions[4].

Safety and Quality Incentives

The AMA continues to strongly oppose the use of reduced Commonwealth payments to 'incentivise' quality patient care. This approach is not supported by any credible evidence. The AMA supports public hospitals providing best practice care, but to make this affordable/possible, Commonwealth contributions should also be calculated on the cost of best practice care instead of average cost care. Funding penalties on top of average cost Commonwealth payments do not help public hospitals operate in crisis and still deliver best practice patient care.

The latest safety and quality penalty will apply to avoidable readmissions from 1 July 2021. AMA especially disagrees with IHPA's decision to apply zero Commonwealth funding to all 'avoidable' readmissions. The weight of this penalty is convenient for IHPA, but it is certainly not aligned with evidence. For some patient cohorts staying well in the community post discharge depends on much more than the quality of care these patients receive during the index admission and whether hospital staff provided appropriate discharge planning. Even if readmission penalties are risk-adjusted for patient chronicity, zero funding remains inappropriate for complex patients who can't access the community based supports they need to manage their disease, or patients listed above who frequently don't have a safe discharge destination. AMA doesn't consider financial penalties are efficacious, but if a penalty is used, it should not apply until a hospital readmission rate exceeds the national benchmark for the

[4] New South Wales has implemented Lumos to provide the cross sector, real time patient data. It is not clear how much progress other jurisdictions have made on similar solutions.

identical treatment, adjusted to account for patient complexity and patient circumstance post discharge.

The penalty timing also makes the 1 July 2021 start date for avoidable readmission penalties problematic because widespread trials on innovative funding models have not yet started. It is also inappropriate to start the IHPA readmission penalties at the time demand pressure on beds is overwhelming hospitals and they are under pressure to discharge patients as soon as possible to allow emergency patients who are also at risk to be admitted. The AMA strongly urges IHPA to reconsider the current design, severity and timing of avoidable readmission penalties.

Evaluation of safety and quality incentives

AMA welcomes the evaluation of the penalty-based safety and quality framework. IHPA's role to make recommendations on the severity and type of penalties puts IHPA in a conflict of interest. This, combined with the paucity of international evidence to show a direct causal link between funding penalties and better patient outcomes, makes a strong case in favour of an independent evaluation.

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