23 July 2021
Independent Hospital Pricing Authority

RESPONSE TO CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2022-23

Thank you for the opportunity to contribute to the consultation on the Pricing Framework for Australian Public Hospital Services 2021-2022. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 15% of healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly.

The following comments relate to the Consultation paper on the pricing framework released by IHPA and our responses to the consultation questions listed in the document.

Chapter 2

What feedback do you have on IHPA's proposed approach for using the 2019–20 cost and activity data to assess the short term activity and potential pricing impacts of COVID-19 on NEP22?

- As noted by IHPA, 2019-20 costs will be skewed based on the months that national restrictions were in place. IHPA should observe the process undertaken by NSW Health who have split the costings by 3 months, 9 months, and 12 months. However, this will also need to account for the differences that will be observed in other states that have experienced longer lockdowns and snap lockdowns that result in procedural delays in the weeks that follow.
- As elective surgeries have resumed, the public system requires additional support from the private system in order to remediate waiting lists and manage the back-log of surgeries that were on hold during the quarantine restrictions, particularly for category 2 and 3 procedures. Some states have refrained from these surgeries to deal with the growing bed block in their public hospitals. Reductions in preventative screening and clinical presentations indicate many patients may delay seeking medical interventions. As patients have had surgeries delayed from lockdowns, they are presenting with greater acuity than they would have.

Are there any recommendations for how IHPA should account for COVID-19 in the coming years?

- As IHPA have noted, there have been many changes to hospital services as a result of COVID-19, particularly for screening, PPE usage, additional cleaning, and models of care. These additional costs are going to continue into the future and will need to be accounted for in longer term impacts to the health system. It would be beneficial for IHPA to better define how these long term impacts will be measured with the lasting effects of COVID on the health system.

- For public hospitals to utilise private hospitals, this will likely come at a higher cost per episode. Similarly, any use of overtime to extend services will increase the cost per case. These increases are likely to vary across states and territories dependent upon the level of restrictions that were implemented over time.
- Considerable costs have been incurred as a result of additional screening measures including additional staff to monitor entrances, policing visiting, and making on spot infection determinations. Hospitals testing patients receive pre-surgical COVID testing, requiring administrative follow which has also slowed down admission processes. Future considerations for validation of COVID vaccination status will also need to be considered.
- The additional management of theatre processes requires additional time between cases for cleaning and preparation time for staff due to increased PPE requirements including a PPE observer to ensure the appropriate preparation of each staff member.
- There is considerable increase in the costs associated with PPE use including the additional time between patient encounters and providing care. These leads to increases in costs per case. Shortages and requirements to maintain stockpiles have caused the price of medical products to rise exorbitantly. These rising costs of necessary supplies will need to be considered including the impacts on supply channels.
- Processes for discharge have changed as some patients express the desire to be discharged home as soon as clinically stable to seek care in the home as an alternative to in hospital. This process for addressing needs may not be well developed in all cases and pressure upon the nursing staff numbers has complicated this care process. Many nurses have chosen to reduce hours, work in areas that carry less risk or have been reduced in numbers due to COVID contact. While some moderate gains in length of stay may be evident for some procedures, the controls on Category 1 surgeries negate any hospital efficiency while not always being the most efficient solution for staffing.
- With the need for more nurses to work across testing and vaccination sites, hospital services are experiencing a significant gap in workforce capacity. This has led to additional hire costs to attract, upskill, and retain staff in a rapid timeframe.
- Activity levels have also been impacted. Surgical efficiencies have been lost through the inability to arrange 'common' procedure theatre lists and the method for surgical theatre time shifting to 'urgent' rather than speciality driven. Noticeable decreases in ED presentations, consultant appointments, and GP attendance indicate that there will be latent conditions not adequately addressed which implies late presentation being a feature of care needs. Patients with higher acuity needs when presenting will impact upon resource consumption for future services.
- Telehealth has led to a significant change in the hospital model of care. The upfront costs of implementing telehealth can be significant, with ongoing costs managed over time. Antenatal, rehabilitation, and mental education and group therapy has successfully transitioned to video telehealth platforms with investment in rapid scale up by hospitals. There has also been greater use in telehealth by consultants and pre-admission for initial screening. Patients have expressed greater satisfaction with telehealth including the ease of communication and accessibility of care. While rates of telehealth will reduce with a return to in person appointments, some telehealth services continue to offer better access for patients and should continue uninterrupted according to patient preferences.

Chapter 5

Do you support the proposal to establish standard development cycles for all classification systems??

- CHA does agree with the proposal to establish standard development cycles for classification systems provided they are determined by need and can respond to shifts in technology and innovation as required.

Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?

- Hospitals have suggested that the use of a frailty risk score can be problematic when used as part of the geriatric evaluation because this classification is retrospective.
- The cognitive FIM score should not be excluded as a variable as patients presenting with mental illness might not be captured in any other way according to the classes.

How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?

- CHA suggests delaying the costing study as COVID may have drastically changed the settings for non-admitted care. Additionally, ongoing lockdowns across the country have meant the system has not been able to stabilise as the consultation paper suggests. Staff pressures and clinical restrictions in the current environment are not conducive to the nature of the study.

5.2.3 Phasing out support for older AR-DRG versions

- CHA has communicated their concern with the phase out timeframes that have been suggested. More support is needed to move systems to newer versions. As some health fund contracts cover a 3-year period, all versions of DRGs must be supported for at least 5 years to allow providers and health funds time to update funding models and contracts. The proposed timing would take into consideration any required IT system changes, modelling and validations to avoid the possibility of any catastrophic unintended consequences, particularly for small hospitals with narrow casemix. Hospitals have agreed there is a burden in the current cycles and an appetite to extend the time between version releases. It is important to have greater commitment by the private sector to participate in the private NHCDC data collection.

5.7 Teaching and Training

- There has been a radical shift in the use of precision healthcare and mainstreaming genomics to treat a wide range of cancers illnesses to tailor treatments to the individual. However, the medical workforce is still struggling to catch up on genomics-readiness and literacy. The Clinical Genetics Clinics need to be given more resources, via appropriately weighed activity, to take into account the time and resource requirements, to be able to provide adequate genomics teaching and training to assist in getting the next generation medical workforce ready for personalised genomic medicine.

Chapter 6

What evidence is there to support increased costs for genetic services or socioeconomic status?

Genetic services are costly for the following reasons:

- Testing requires the use of expensive highly specialised pathology: due to its associated genetic/genomic tests that range from a few hundred to a few thousand dollars per test, most of which are not publicly funded via Medicare;
- There are increased costs associated with the time resource requirement due to complexities surrounding a genetic consultation which takes on average 1 hour per patient;
- There are increased costs associated with an intensive human resource requirement: often a clinical geneticist (specialist doctor) needs a genetic counsellor support (allied health) in the same clinic setting. A family will often undergo significant psychosocial issues by the time they get to be seen at a genetics service towards the end of their diagnostic journey.

- The long waitlist at most genetic services is another indicator that most genetic clinics are under-funded. This impacts patient care, leads to diagnostic delays which in turn leads to inefficient treatment and/or unnecessary investigative interventions.
- The traditional funding model for genetic services is not sustainable in the long-term, and an alternative funding model including appropriately weighed clinic activity considered.
- Catholic health providers are committed to providing equitable access to these genetic services. In some states, due to the complex nature of these test and services, Catholic providers are the only suppliers of genetic testing for certain conditions. CHA requests that consideration be given to examining and appropriately funding the screening and treatment of patients who are socioeconomically disadvantaged.

Chapter 10

What other considerations should IHPA have in investigating innovative models of care and exploring trials of new and innovative funding approaches?

Genetics

- An alternate funding model is critical for the long-term sustainability of Clinical Genetics services as reasoned above. The alternate funding model may include a commonwealth-funded high-cost highly specialised pathology program that will increase the efficiency and reduce genomic equity gap for all Australians. Making a genetic diagnosis in one person who resides in a particular state and territory would have significant repercussions for the extended members of his/her family who may reside in other states and territories, which may include disease prevention, risk management, and reproductive planning, all of which will lead to reduced healthcare costs for the Australian Commonwealth. Centralising funding for high-cost pathology will ensure all Australians have equal access to genomic testing, which is not limited to certain regions that are better funded than the others.
- A hybrid model of commonwealth-funded genomic testing with block-funded and/or ABF funding at each state and territory should be considered for genetic services.

Heart Lung Transplantation

- NSW relies on donated Organs from other States to meet the population need. This necessitates the use of special equipment called Organ Care Systems to keep the Organs perfused and viable. In recent years flight costs have been incurred in order to retrieve organs in a timely manner than can be provided through other tissue donation retrievals. However, the NWAU doesn't reflect these costs. CHA appreciates that this is under consideration, but perhaps utilising a different funding model to address Heart and Lung Organ Retrieval could be considered on a state by state basis separate to the NWAU for the Transplant DRGs.