# Response to the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24

Thank you for giving the opportunity to respond to the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24* ("the Pricing Framework 2023-24"). The comments in this response that follows are from our own professional background as health information manager, health informatician and as health executives with the knowledge and expertise. We would also like to highlight that our views and recommendations does not reflect any organisation or professional body view or responses to the Pricing Framework 2023-24.

In going forward with the Pricing Framework 2023-24, we would like to suggest few scenarios to be investigated further by Independent Hospital Pricing Authority where services are provided in a country health care setting.

In the country health care setting, the service delivery and client presentation are diverse and complex along with pressures of demographics, socioeconomic impact and distance to health facilities that are adequately resourced. As such, it is not always possible to deliver patient care and services based on a single Pricing Framework that is governed by the *National Health Reform Agreement 2011* (NHRA). It is recommended that we understand a Pricing Framework that is holistic and comprehensive and considers country health care settings and the complexities involved in providing a high level of comprehensive health care to communities that are geographically dispersed.

For example:

1. **Aboriginal Health Care Workers**

Aboriginal Health Care Workers (Aboriginal Liaison Officer ) have the multiple health care and human services interactions with an Aboriginal client when they visit a public health care facility at a regional or remote location. Some of the interactions are complex in delivering care in a country health care setting where the health care facility itself is the last resort. Alternative to any kind of hospital health care and human services care are limited. Another detriment to health care delivery is availability of trained professionals that are working within the scope of practice in a remote location. Staff development and recruitment in a remote location is very demanding and arduous. Health determinant targets are not always met at a country health care setting consistently.

From country health perspective it is recommended that IHPA investigate the implementation of a Tier 2 Clinic to identify Aboriginal Liaison Officer (ALO) Health Workers service event within the Hospital and Community setting to enable country health to respond to the closing the gap initiatives and other Aboriginal health initiatives and directives.

2. **Service Delivery Modes in country health services**

In country health care, the services that are delivered in most cases are "blended" in which the patient journey within the system navigates through multiple funding arrangement and care settings. A client/patient journey within a remote health care facility flows between different settings such as from a public hospital to non-public hospital settings. The "blended services" model of care delivery environment can work more efficiently in a virtual care setting, supported by a multidisciplinary workforce. This brings about more expertise to the care received by the client/patient. For instance, health care can be provided by a Medical Practitioner that is not

physically located in the local area and can deliver support health care services to multiple remote locations.

The model enables nurse practitioner, allied health practitioners to provide specialist care . Mental health professionals can provide mental health services to wider range of clients. Allied health professionals can provide virtual allied health services to remote locations where staff availability of allied health professionals is difficult to meat.

We recommend that from country health perspective that IHPA investigate the cost variation between Virtual care and Faces-to-Face patient presentations, conventional care models and structure.

In the virtual care environment, it would be prudent to implement a comprehensive funding envelope to capture all the disparate support and services that clients receive through a virtual medium.

**3. Human Services**

In a country health care setting the health care facility is the last resort. The health care facility in many instances acts as and provides human services that pertain to:

a. Family domestic violence
b. Department of Communities
c. Housing/Accommodation
d. Provision of food
e. Provision, availability and retention of employment
f. Provision, availability and retention within the education system

IHPA should expand the non-admitted activity data collections and costing environment to include these services to ensure a holistic view of health and community service can be understood at a national and local level.

**4. Going forward**

A Pricing Framework going forward, especially in the revision of the current NHRA, would need to investigate and explore a holistic and pragmatic approach to delivery of services in a country health care facility.

Segregations and compartmentalisation of services are quite difficult in country health care service delivery settings. At times, it is impossible due to the lack of data and information system infrastructure that are integrated, interoperable and interconnected. The responsibility of reporting and governance lies in a multitude of government tiers such as, Local, State and Commonwealth. At the same time, the care settings are both State and Commonwealth responsibilities such as, public hospital and primary care.

**5. The Evolution of the Pricing Framework to new funding paradigm**

With the review of the Pricing Framework under the NHRA, it is important to understand, even services in a public health facility are quite evolved and much more client focused than just looking at a mean average price at a product level. The pricing needs to investigate the variation between mean average and median average. As already discuss IHPA need to investigate the whole cost of production of service to the client/patient. Simply pricing an “activity” average is no longer effective

or feasible. In country health settings the true cost of service has a high level of fixed cost. This fixed cost needs to be reflected in the base line cost. Accounting for remoteness is not adequate, distance and provisions of other auxiliary services must be taken into account. We would encourage Independent Hospital Pricing Authority to conduct a study on cost pressure consultation across all jurisdictions that have high level of country health care facilities to understand the cost pressure of providing services in a country health care setting across Australia. It is the best opportunity we have before we embark on a review and reform of the NHRA in 2025. It is necessary to understand that in a country health setting, the services are quite blended and interconnected and co-dependent. They cannot be compartmentalised into a single agreement or a Pricing Framework. At the same time, the current infrastructure and staffing requirement are a huge barrier for service provisions. Clients' needs have changed with ageing population, prevalence of chronic conditions and care delivery closer to home. It is also becoming evident that patients and clients want to have more engagement in their health care and decision-making opportunities. Continuum of care is of great value when it comes to keeping patients out of hospitals. In country health care settings, it would be beneficial for governments to explore virtual care through digital health initiatives.

**6. Addressing the long implication of COVID-19 pandemic**

The COVID-19 pandemic has highlighted the importance of care delivery in a virtual environment via telephone, videoconferencing and social media. We would encourage that the Pricing Framework also look at the long COVID-19 impact on remote and regional communities and their needs to health care. Along with the impact on the burden of disease in country health care. It is well documented that the impact of COVID-19 pandemic in the chronic and non-chronic diseases has increased. Health services will have to address this implication in the coming years. The current pricing model do not fully encapsulate the cost of service that will be incurred going forward from this current pandemic.

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