Victorian Healthcare Association
Vision • Value • Voice

Submission

Consultation response: Pricing Framework for Australian Public Hospital Services 2023–24

About the VHA

The Victorian Healthcare Association (VHA) is the peak body supporting Victoria's public health and community health services to deliver high-quality care. Established in 1938, the VHA represents Victoria's diverse public healthcare sector, including public hospitals, aged care and community health services.

As well as providing a unified voice for the sector, the VHA delivers value for its members by offering tailored professional development programs, networking opportunities, and informative events. The VHA advocates on behalf of its members on sector-critical issues by engaging and influencing key decision-makers involved in policy development and system reform.

Executive summary

In response to the Independent Hospital Pricing Authority's (IHPA) consultation on the Pricing Framework for Australian Public Hospital Services 2023–24, the VHA recommends that IHPA:

- factor in the changing nature of activity that has affected Victoria for assessing COVID-19 impacts on the 2020–21 data
- extend the scope of public hospital services so urgent care centres are eligible for funding
- investigate pressures on rural and regional services, and consider further adjustments
- investigate innovative models of virtual care in Victoria and consider developing an adjustment to encourage its use.

Introduction

The VHA is pleased to respond to the IHPA consultation on the Pricing Framework for Australian Public Hospital Services 2023–24 (referred to as NEP23).

A key focus for the VHA continues to be how the effects of COVID-19, direct and indirect, will be encapsulated in the pricing for NEP23. It is vital that NEP23 continues to reflect the impact of the COVID-19 pandemic on the cost of care. Victoria's health system has been the most disrupted during the pandemic, and continues to face the diverse impacts of COVID-19, which are expected to continue for the foreseeable future.

The VHA also believes that NEP23 offers a vital opportunity to support rural and regional care through extension of scope to urgent care centres, investigating an adjustment for patient transport in rural areas and consideration of cost pressures for regional or remote hospitals. Virtual care also offers a key route to support care delivery.

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Consultation and response

Impacts of COVID-19

- Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

The VHA welcomes IHPA's consideration of the impact of COVID-19 on hospital activity and pricing. Overall, we support IHPA's proposed approach for assessing COVID-19 impacts in the development of NEP23 – particularly as the data set to inform NEP23 will include Victoria's second lockdown, which had a drastic impact on traditional hospital activity. We are also pleased to see IHPA's recognition of some of the wider implications of the pandemic, including the increased complexity of elective surgery cases due to delayed care stemming from the pandemic, the use of additional personal protective equipment, and the impact of workforce shortages.

Changing nature of activity

In terms of specific considerations, the VHA would urge IHPA to focus on a range of factors that are present in the 2020–21 data and beyond – such as the changing nature of activity through the year and subsequent changes and trends which inform understanding of 2020–21 data.

In regard to the changing nature of activity through the 2020–21 period, IHPA should consider the impact of intense periods of demand. The performance data from the Victorian Health Services Performance dashboard (the dashboard) shows that there were more emergency department (ED) presentations in 2019–20 than in 2020–21, yet the data also demonstrates the range that Victorian health services faced during the 2020–21 period:

> **there were almost 120,000 more presentations in Q4 2020–21 compared to Q1 2020–21, while Q3 2020–21 saw the highest number of presentations that Victoria has ever recorded.**

These periods of intense activity, which are mirrored in year-highs in the number of elective surgery patients treated in Q3 and Q4, have an impact on costs for services. For instance, if IHPA cost data analysis has 'indicated that hospital expenditure remained relatively stable throughout the COVID-19-impacted period despite the significant reduction in activity', due to increased cost of care during the pandemic, then record demand for care during a period of similar restrictions and requirements means that services will have incurred increased costs – such as through staffing, delayed care and delayed discharge.

This information should also be reflected in costing as increased activity, on an already strained system, is likely to lead to worse outcomes, which services are then punished for, noting IHPA's adjustments for sentinel events, hospital acquired complications, and avoidable hospital readmissions. While health services and their workforce responded ably and admirably during intense demand and a continuing pandemic, the dashboard highlights that the Victorian health system suffered worsening performance on key metrics during 2020-21 – including ambulance patient transfers within 40 minutes, emergency patients treated within the clinically recommended time and the percentage of patients with a stay of less than four hours. While this does not demonstrate worse outcomes, this factor should be taken into consideration.

Emerging trends in care

While NEP23 will be informed by 2020–21 cost data, preliminary data for 2021–22 should be taken into account by IHPA to understand key developments that should be reflected in NEP23. For instance, a key trend that began in 2020–21 and has continued in 2021–22 has been increased patient acuity in elective and emergency demand. In regard to elective surgery, the dashboard highlights the difference in the acuity composition of the elective surgery wait list; in Q2 2020–21, Category 2 patients accounted for 43 per cent of the entire list – by Q2 2021–22 they accounted for 48 per cent. This rise in Category 2 patients was matched by a decrease in the proportion of the wait list that were Category 3 patients from 55 to 50 per cent. There is a similar trend in emergency demand – for the same period, Category 2 and 3 presentations as a percentage of total presentations increased, while Category 3 and 4 increased.

Scope of public health services

The VHA recommends that IHPA extends the scope of public hospital services so that urgent care centres (UCCs), and the care provided within them, becomes eligible for Commonwealth funding under the National Health Reform Agreement (NHRA).

There are approximately 45 VHA members that have a UCC within their health service. UCCs are one component of a public rural health service, equipped to provide first-line emergency care to patients. They provide non-admitted patient care for rural communities, treating urgent (and if necessary, life-threatening) cases where an ED may not be appropriate or immediately accessible.

UCCs have a target to treat 93,000 presentations in 2022–23, and are a vital tool in Victoria's health system.

UCCs are currently excluded from NHRA funding on the basis that they are not considered an emergency department, or a substitute for an emergency department, so are therefore not 'in-scope' – ineligible for both emergency and non-admitted care funding. The VHA urges reconsideration of this definition by IHPA, which unnecessarily limits care and fails to acknowledge the reality of care in Victoria. This definition also appears to go against IHPA's Pricing Guidelines, including the overarching and system guideline principles, such as efficiency, fairness and minimising undesirable and inadvertent consequences. We believe that the current NHRA, and its Addendum, allow for inclusion of UCCs to be eligible for funding – similar to how out-of-hospital funding is being supported by the NHRA through the Victorian 'Better At Home' program. There is further impetus for this change through IHPA's consideration of virtual care in the consultation document, with direct recognition that emergency care is provided outside of EDs in UCCs through telehealth. If the Pricing Authority has approved the inclusion of telehealth video consultations delivered by emergency departments on the General List of In-Scope Public Hospital Services 2022–23, then UCCs should be funded their role in the same care delivery.

This re-scoping proposal is a fundamental step to establishing a whole-of-system response, especially as a more national conversation develops around the NHRA. At the recent federal election, the VHA advocated for out-of-hospital care to be included in the next agreement. In the meantime, the VHA believes IHPA should not constrain activity that supports or limits hospital or ED activity.

Classifications used to describe and price public health services

- Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?
- Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?
- Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

The VHA does not foresee any barriers to using AR-DRG Version 11.0 to price admitted acute services for NEP23, or to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23. We support the proposal to recognise frailty as a cost driver for subacute care by incorporating the Frailty Related Index of Comorbidities into the classification for geriatric evaluation and management and non-acute episodes of care.

While the VHA does not foresee any barriers to using AMHCC Version 1.0 to price community mental health care for NEP23, we do highlight an additional consideration around its implementation and unintended consequences. We note the concern we raised in last year's submission that activity-based funding (ABF) is increasingly seen as a barrier to providing truly person-centred care, particularly for complex conditions. For example, it is all but impossible for ABF to adequately capture the impact of a person's support network, or lack thereof, or the variability with which people may respond to different types of psycho-social supports. With Victoria implementing the changes recommended by Royal Commission into Victoria's Mental Health System, major changes for community-based care are envisioned which will occur at the same time or just before the implementation of NEP23. With this in mind, we urge consideration of extra support and resourcing for the Victorian implementation of AMHCC Version 1.0, with services likely to be delivering a range of other reforms at the time.

Setting the national efficient price

- Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?
- What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

The VHA recommends that IHPA should prioritise investigating an adjustment for patient transport in rural areas and a new adjustment for socioeconomic status to inform the development of NEP23. In regard to patient transport, as the VHA noted last year, the current adjustments fail to accurately reflect the costs involved for Victorian health services and fail to accurately reflect the costs associated with changes in demographics and demand.

The recent ABS Census 2021 data release showed that regional Victoria experienced a higher rate of growth in population than greater Melbourne.

The pandemic has resulted in further internal migration for holidays and living, increasing demand on rural services, and increasing the need for patient transport. Rural and regional Victorian health services are reporting increased presentations, admissions, and patient transfers, which we believe is reflected in state performance figures for 2020–21 and Ambulance Victoria data.

Similarly, socioeconomic status is increasingly being recognised as a key variable in care in Australia and beyond, such as in the UK's response to health inequalities exposed by the pandemic. The VHA has consistently advocated for greater support to enable access to this segment of the population, who are often harder to engage, and support investigation of an adjustment for care. The High Risk Accommodation Response program, recently discontinued but succeeded by a new Community Connectors program, offers a key case study for IHPA to explore as part of its investigation.

In terms of cost input pressures that should be considered in the development of NEP23, the VHA highlights workforce shortages. While the NHCDC collects data on workforce, it does not collect information on the absence of staff. Workforce shortages have impacted care delivery since 2020, whether through furloughing or an inability to hire/retain staff, and we believe that this will have an impact on the national pricing model.

Setting the national efficient cost

- What cost pressures for regional or remote hospitals should be considered in the development of NEC23?
- What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

The VHA urges that IHPA consider three key cost pressures for regional or remote hospitals: workforce, pandemic demand, and increased activity. These are three factors that have been repeatedly raised to us by members; in response we developed a report outlining the specific workforce concerns. The VHA believes their impact is demonstrated in performance and activity data. We welcome the recognition that there has been an increase in in-reach models of care that have been established in some regional hospitals via telehealth, which is in line with what we have heard from members. We also support the intention to consider how additional cost pressures on regional hospitals as a result of responses to COVID-19 are taken into account in the national pricing model.

As the VHA highlighted last year, there should be consideration of potential unintended consequences when transitioning standalone hospitals that provide specialist mental health services to ABF. Due to the nature of ABF, it has the potential to lead to worse outcomes for patients and failure to deliver the care required. The National Disability Insurance Scheme (NDIS), which utilises ABF, has been found to have added further complexity, created barriers to accessing psychosocial supports, and led to service gaps relating to mental health support. To counteract this, IHPA should explore an adjustment to support care delivery and ensure implementation of ABF does not lead to unintended outcomes.

Future funding models

- How is virtual care delivery captured in information systems and data collections?
- IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?
- What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?

The VHA welcomes IHPA's focus on virtual care delivery throughout the consultation document – and supports the emphasis on this newer form of care delivery.

In terms of how this is captured in information systems and data collections, the VHA is aware of a process to capture the use of telehealth in emergency departments in Victoria. Emergency departments are meant to report this activity to the Victorian Emergency Minimum Dataset (VEMD).

We support IHPA's proposal to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. We also encourage IHPA to investigate the two other examples of virtual care models that were identified in the consultation paper; remote monitoring of COVID-19 positive patients or patients with chronic conditions and providing specialist consultations virtually to people living in rural and remote areas.

Remote monitoring has proven successful in reducing hospital admission in Victoria through the COVID Positive Pathways program – this can be seen through comparisons between the number of cases and the resulting number of hospitalisations, especially in comparison to New South Wales. This has been supported by research, which demonstrates the importance of out-of-hospital care and community health – the VHA has advocated for the extension of the program to other illnesses and chronic conditions.

Similarly, Victorian hospitals have long utilised telehealth to enable remote specialist consultations to rural and regional patients, which enabled a rapid escalation in this approach during the initial phases of the pandemic. This data should be available from services or the Victorian Government.

The VHA also highlights the Victorian Virtual Emergency Department (VVED) as an example of an innovative models of virtual care. Developed by Northern Health, VVED was the first of its kind in Australia, and has recently been expanded state-wide as part of the health system response to pandemic pressures. We believe this has strong potential to reduce pressure on emergency departments, by enabling patients to access clinicians and nurses remotely.

The VHA recommends that IHPA consider an adjustment for innovative models of care and services related to virtual care. A financial support such as this will drive recognition and growth of virtual care and these innovative models – which will encourage improved access to care and more effective use of resources.

The pandemic has highlighted the value of remote virtual care – and it should be considered a benefit, one of the few that exist, to stem from this period. While virtual care is not appropriate for all care delivery, it is an important tool.

An adjustment will help to cement and reward the innovation highlighted in the previous paragraph – and encourage services to look for further opportunities for virtual innovation. IHPA should also consider how such an adjustment could encourage exploration of future funding models – while states and territories want to nominate their own models of care or services for consideration, virtual care is an opportunity to drive the conversation and change, more broadly, forward. The current reimbursement methods in Victoria, based on ABF, have failed to drive wider system changes in regard to virtual care.

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