Victorian Healthcare Association
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Briefing

9 July 2021

Consultation response: Pricing Framework for Australian Public Hospital Services 2022–23

About the Victorian Healthcare Association

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

Introduction

The VHA is pleased to respond to the Independent Hospital Pricing Authority's (IHPA) consultation on the Pricing Framework for Australian Public Hospital Services 2022–23 (referred to as NEP22). While we provide further insight on other issues, the VHA's key focus is on how the effects of COVID-19, direct and indirect, will be encapsulated in the pricing for NEP22. It is vital that NEP22 accurately reflects the impact of the COVID-19 pandemic on the cost of care, as this sets a precedent for how the pricing framework will reflect the ongoing effects of the pandemic on health services. Victoria, whose health system has been the most disrupted during the pandemic, continues to face the diverse impacts of COVID-19, which are expected to continue for the foreseeable future. The pricing should reflect this and should not add to the considerable burden already on the Victorian public health system.

This submission is based on consultation and discussions with VHA member services across a range of issues. The submission is structured around the key themes that encapsulate the questions in the engagement paper.

Submission

Impacts of COVID-19

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

The IHPA's proposed approach for assessing the impact of COVID-19 on NEP22 is appropriate, but should be altered to accurately reflect the longer-term effects of COVID-19, which will influence care while NEP22 is being utilised. While the VHA supports this approach to accurately reflect any variations in cost and care, the IHPA should take a longer-term view of the impact of COVID-19 beyond the initial three-month period that is set to inform NEP22.

Victoria has, so far, been the state most disrupted by the pandemic, with the COVID-19 pandemic continuing to impact the Victorian health system both directly and indirectly. This can be seen in the Victorian Health Services Performance dashboard. The quarterly figures demonstrate that there was a drop in monitored activity in Q2 and Q3 2020; yet health services have reported that the cost of care did not diminish due to the additional cost of delivering care stemming from the restrictions in place at the time. This can be seen by how some performance figures during these periods were down on the same periods in 2019. Since then, the demand for care has exceeded pre-pandemic levels, while the health system has still been attempting to respond to the pandemic and operating under restrictions. This has been further complicated by the rise in acuity of cases, due to delayed primary and preventative care stemming from the pandemic and lockdowns. The Australian Institute for Health and Welfare identified a drop in cancer screening in 2020 compared to 2019, stating that the 'long-term effects of delayed screening during the COVID-19 pandemic will not be known for some time'. These trends will continue to be felt in

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NEP22 and beyond – yet the pricing, currently, for NEP22 will only be adjusted for a three-month period that will not reflect the true impact of the pandemic.

The VHA recommends there should be greater consideration of the regional impact of the pandemic, noting that Victoria underwent the longest lockdown and therefore has been disproportionately affected by the pandemic. Pricing needs to reflect the pressure the health system is under and the increased costs of care due to the pandemic; the IHPA should make a commitment that there will be no reduction in pricing stemming from the impact of any pandemic decisions in NEP22 and beyond. To support this, the VHA recommends that the IHPA should explore a COVID-19 adjustment for pricing which can be applied at a state-wide level to support the post-pandemic response. At the very least, this adjustment should be available to support the increase in more intensive treatments connected to delayed care. This will help enable health systems to respond as they deal with the impact of the pandemic, including increased presentations and greater demand for more acute treatment.

Classifications

- *Do you support the proposal to establish standard development cycles for all classification systems?*
- *How can IHPA support state and territory readiness for recommencing the non-admitted care costing study?*
- *Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP22?*
- *Are there any impediments to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22?*

In regard to classifications, the VHA supports the proposal to establish standard development cycles for all classification systems, as it provides greater consistency. The VHA also supports the use of AN-SNAP Version 5.0, particularly its proposal to recognise frailty as a cost driver for subacute care by incorporating a Frailty Risk Score. This is of particular relevance to Victoria as the Victorian public health system is the largest provider of public sector residential aged care in Australia, with 178 public sector residential aged care services delivering approximately 10 per cent of operational places across Victoria. Run by small and rural hospitals as well as larger regional and metropolitan health services, public sector providers of residential aged care are often co-located with acute services, with over 89 per cent of all Victorian public sector residential facilities in regional and rural and areas.

However, in recommencing the non-admitted care costing study, the IHPA should explore longer timeframes to enable the Victorian health system to respond and engage. While the IHPA may believe that 'the COVID-19 situation and activity and service delivery in the non-admitted setting continues to stabilise', this is not the reality in Victoria, as demonstrated above.

The move to pricing admitted and community mental health care using AMHCC Version 1.0 for NEP22 is aligned with developments in Victoria, with the Royal Commission into Victoria's Mental Health System recommending that an activity-based funding (ABF) model be trialled and implemented for both bed-based and community-based mental health and wellbeing services. While there are no impediments to using AMHCC Version 1.0 for NEP22, and it should improve data collection alongside state-level changes, the VHA urges caution over the move to ABF – the year of shadow-pricing in 2021-22 needs to be used effectively to identify any issues. While ABF for public health services has been extremely successful in driving financial efficiency, it is increasingly seen as a barrier to providing truly person-centred care, particularly for complex conditions. For example, it is all but impossible for an activity-based funding model 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.

The VHA has previously advocated that activity-based funding should be replaced with outcomes-based funding models for conditions or services that cannot be easily costed such as mental illness. Aligned with this, we recommend that the IHPA begin exploring the potential to utilise value- or outcome-based funding models for mental health care for future NEPs. This is supported by the Royal Commission into Victoria's Mental Health System,

which acknowledges that activity-based funding should be a first step before ultimately moving to a value-based model.

National Efficient Price

- *What costs associated with patient transport in rural areas are not adequately captured by existing adjustments within the national pricing model?*
- *What evidence is there to support any additional adjustments that IHPA should consider for NEP22?*

Regarding patient transport in rural areas, there is a long-standing issue of rural Victorian health services not being deemed adequately remote to receive further support when in reality, and in regard to the factors that affect service delivery, they are remote. This means that the current adjustments fail to accurately reflect the costs involved for Victorian health services. These adjustments also fail to accurately reflect the costs associated with changes in demographics and demand. The pandemic has resulted in further internal migration for holidays and living, increasing demand on rural services, and increasing the need for patient transport. Victorian health services are reporting increased presentations, admissions, and patient transfers, which is reflected in the latest quarterly state performance figures. This increased demand impacts on the ability of services and Ambulance Victoria to then transport patients, leading to delayed transfers, and increased cost of care. A further adjustment for patient transport in rural areas should be implemented for NEP22.

For further adjustments, the VHA again recommends that the IHPA explore a COVID-19 adjustment for pricing which can be applied at a state-wide level to support the post-pandemic response, as recommended above. This will help enable health systems to respond as they deal with the impact of the pandemic, including increased presentations and greater demand for more acute treatment.

National Efficient Cost

- *What are the potential consequences of transitioning block funded standalone hospitals that provide specialist mental health services to ABF?*

As highlighted above, while the move to ABF has its benefits, it fails to accurately reflect the true costs of care, especially for complex conditions. Standalone hospitals that provide specialist mental health services are not suitable for ABF; it has the potential to lead to worse outcomes for patients and failure to deliver the care required due to cost concerns. This can be seen with the impact of the National Disability Insurance Scheme (NDIS), which is meant to provide care to those with severe mental health issues, and utilises an element of ABF through its individualised funding packages. The NDIS has been found to have added further complexity, created barriers to accessing psychosocial supports, and led to service gaps in regards to mental health support. The IHPA should evaluate the impact of ABF on other areas of mental health before exploring changing the funding model in this area. It should also explore the potential for outcomes-based funding models to more accurately reflect the costs required to treat patients in these settings.

Future funding models

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

The VHA would encourage the IHPA to have greater consideration of contextual factors for each state in investigating innovative models of care and exploring trials of new and innovative funding approaches. The engagement paper identifies a range of critical success factors, yet there is no consideration of the capacity and capability of the health system to implement trials or pilots. As has been made clear, the Victorian health system is currently under pressure – this needs to be recognised as having an impact on the viability of exploring alternative funding approaches.

Safety and quality

- *What pricing and funding approaches should be explored by IHPA for reducing avoidable and preventable hospitalisations?*
- *What assessment criteria should IHPA consider in evaluating the merit of different pricing and funding approaches for reducing avoidable and preventable hospitalisations?*

To support reducing avoidable and preventable hospitalisations, the VHA urges a focus on preventive health funding, as pricing and funding approaches should be aligned with the soon-to-be-released National Preventive Health Strategy. This includes exploring funding approaches which encourage integrated care and collaboration with other health services and other related stakeholders, such as community health, which can support positive preventive outcomes in the community. As care moves beyond hospital walls, hospital funding needs to be able to move with it and encourage partnerships which put patient needs above unnecessary hospitalisations, which benefits nobody. Preventive health has a direct impact on admissions and the risk of avoidable hospitalisations, so should be supported as part of this approach.

The focus, in terms of funding criteria, should be based on patient outcomes, as this is at the heart of reducing avoidable and preventable hospitalisations. However, this should not be encouraged via a punitive approach on health services and their funding – the pandemic is expected to result in greater preventable hospitalisations due to increased acuity of patients connected to delayed access to care, which health services should not be punished for.

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