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Prof. Michael Pervan
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Independent Health and Aged Care Pricing Authority (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25

Dear Prof. Pervan,

Thank you for the opportunity to respond to the Independent Health and Aged Care Pricing Authority (IHACPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2024-25.

We write in our capacity as researchers at the Australian National University. Natalie Bryant is a Sir Roland Wilson Pat Turner PhD Scholar and a Yuin woman from the South Coast of New South Wales. Her doctoral research investigates Australian health system structures in the context of race and self-determination. Dr Francis Markham is a non-Indigenous scholar whose research and teaching focuses on a range of Indigenous public policy issues, including administrative and funding arrangements.

Our response to the Consultation Paper broadly addresses how Aboriginal and Torres Strait Islander Australians are impacted by the current policy framework and governance arrangements for public hospital services. We acknowledged that the role of IHACPA is relatively narrow. However, it is important to consider the broader impact the policy framework has on Aboriginal and Torres Strait Islander Australians.

In this submission, we want to make one key recommendation: That IHACPA prevent the further marginalisation of Aboriginal and Torres Strait Islander Australians by ensuring that they have a role in the development and implementation of policies that affect them.

The challenges for Aboriginal and Torres Strait Islander Australians

It is well understood that Aboriginal and Torres Strait Islander Australians do not have the same life expectancy as non-Indigenous Australians. There was approximately eight years difference in the life expectancy of an Aboriginal and Torres Strait Islander Australian compared to non-Indigenous Australians when this was last measured using data collected between 2015 and 2017. Death registration data from 2016-2021 suggests that this gap may be widening, with Indigenous standardized death rates increasing from 9.0 to 9.9 per 1,000, while non-Indigenous standardized death rates have fallen from 5.4 to 5.0 per 1,000.[1]

Many of the challenges facing Aboriginal and Torres Strait Islander Australians are a result of the contemporary impacts of colonialism which continues to be felt by Aboriginal and Torres Strait Islander people today. These include generational trauma, institutional racism and lack of access to basic health services across the life course.

There has been an ongoing failure of health authorities and governments to actively address this at a system-level. In a report to the Anti-Discrimination Commissioner of Queensland, Marrie noted the invisibility of Indigenous peoples in the National Health Reform Agreement which he called the statutory blueprint for state and territory public health services. As a result of this invisibility, he went so far as to called the NHRA the structural source of institutional racism in Health and Hospital Services (Marrie 2017).

Indigenous people have little control over the hospital services they use. Focusing on a single HHS in Qld, Bourke and colleagues noted that in an HHS where Indigenous peoples accounted for up to one-third of hospital admissions, there was no Indigenous representation in the governance structure and no mechanism to consult with the local Indigenous community (Bourke, Marrie, and Marrie 2019). The situation they describe is not unusual in Australia's public hospital system.

The role of race and racism on health care access and outcomes has been considered in academic scholarship (Watego, Singh, and Macoun 2021; Baba, Brolan, and Hill 2014; Paradies 2016) however this does not appear to have carried through to the policy framework and governance arrangements of public hospital services. There have been a number of systematic reviews of racism (e.g. Ben et al. 2017; FitzGerald and Hurst 2017; Paradies, Truong, and Priest 2014; Williams and Mohammed 2009). These reviews find that racism impacts on access to healthcare, treatment received and levels of care. This is supported by specific reviews in relation to clinical areas that show that Aboriginal and Torres Strait Islander Australians do not receive the same level of care as non-Indigenous people. There are disparities in access to kidney transplantation, burns care and coronary angiography rates for Aboriginal and Torres Strait Islander People (Cass et al. 2004; Khanal et al. 2018;

[1] Australian Bureau of Statistics (2022). Deaths, 2021.
https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release

Tavella et al. 2016; Coombes et al. 2020) along with a general discrepancies in relation to the number of procedures provided to Indigenous Peoples in comparison to non-Indigenous peoples (Cunningham 2002).

Many Aboriginal and Torres Strait Islander people also require services that are tailored to their particular needs and preferences. Models of care need to recognise and support Indigenous practices and values associated with caregiving. If there is any hope of closing the gap in life expectancy there is a need for culturally appropriate hospital care. There needs to be a significant change to hospital models of care to incorporate Indigenous peoples' preferences of language, cultural ontologies and priorities as well as considerations of wellness. All health services including mainstream and non-community-controlled services need to be culturally safe and appropriate.

It has been identified in the hospital costing and pricing framework that there is an additional cost to providing care to Aboriginal and Torres Strait Islander Australians within the public hospital system. Despite this recognition, Aboriginal and Torres Strait Islander Australians have been rendered invisible in many of the policy decisions in the past. This includes the policy changes that have occurred in public hospitals in relation to activity based funding. It is a mistake to carry forward this past erasure into the ongoing policy framework for public hospital services.

The importance of having Aboriginal and Torres Strait Islander Australians front and centre in the policy framework

The National Health Reform Agreement (NHRA) has been described as the structural source if institutional racism in the health and hospital services.[2] A significant reason for this is the invisibility of Aboriginal and Torres Strait Islanders in the NHRA and the subsequent policy documents developed by the (then) Independent Hospital Pricing Authority. This includes the Pricing Framework for Australian Public Hospitals in which the only reference to Aboriginal and Torres Strait Islander Australians relates to them being an unavoidable cost to the system therefore requiring a pricing adjustment.[3]

While there may not be any ill-intent behind the invisibility of Aboriginal and Torres Strait Islander Australians, it risks embedding an existing issue —the under-servicing of Aboriginal and Torres Strait Islander Australians — into the federal funding framework. It does not consider the unmet health need of Aboriginal and Torres Strait Islander Australians estimated to be approx. $4.4 billion per year by the National Aboriginal Community

[2] Marrie, Adrian. "Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospitals and Health Services: Report to Commissioner Kevin Cocks AM." Submission. Bukal Consultancy Services, 2017, 2010.
[3] Independent Health and Aged Care Pricing Authority. "Pricing Framework for Australian Public Hospital Services 2022–23," 19

Controlled Health Organisation (NACCHO).[4] Nor does it engage with the principles of the United Nations Declaration on the Rights of Indigenous Peoples. One of the fundament principles of the United Nations Declaration on the Rights of Indigenous Peoples is that Indigenous peoples have the right to access the same standard of physical and mental health and social services, as other people, something which requires that cultural, political and socioeconomic difference be recognised and responded to (Australian Human Rights Commission 2010, 20).

With this background, it is important to reflect on the impact of the policy framework for pricing of public hospital services. The pricing framework principles have remained largely unchanged since development. They perpetuate an existing issue of rendering Aboriginal and Torres Strait Islander Australians invisible in policy. The Indigenous adjustment is based on historic cost but does not address the issues of unmet need and underservicing. The unmet needs and under-servicing of Aboriginal and Torres Strait Islander people is unlikely to be achieved without additional expenditure above-and-beyond the current per-episode costs of care. Additional resourcing will be required to address unmet needs, and accordingly a funding system that locks in current costs provides no basis for going beyond the status quo to achieve Indigenous health equity.

The public hospital pricing framework does not incorporate any accountability measures in relation to where the additional funding associated with Aboriginal and Torres Strait Islander peoples is spent. It is unclear whether funding allocated through an Indigenous adjustment is spent on Indigenous people or areas of priority identified by Indigenous peoples. Do these funds go towards programs for Aboriginal and Torres Strait Islander Australians or to improve the cultural safety of mainstream services, or do they simply go into a global budget?

The importance of including Aboriginal and Torres Strait Islander Australians in governance structures and consultation

It is vital to ensure that there is Aboriginal and Torres Strait Islander representation in the governance structures. The National Agreement on Closing the Gap, agreed to by all Australian Governments and by the Coalition of Peaks[5] commits all Governments to a 'full and genuine partnership' when it comes 'policy making that impacts on the lives of Aboriginal and Torres Strait Islander people'.[6] It is undeniable that the public hospital policy framework affects Aboriginal and Torres Strait Islander people. As such, it is incumbent on IHACPA to involve Aboriginal and Torres Strait Islander people in the ongoing development of pricing models and overseeing their implementation as well as consider alternative models of care and funding models.

[4] National Aboriginal Community Controlled Health Organisation, and Equity Economics. "Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians," May 2022, 3.
[5] An alliance comprised of over 80 Aboriginal and Torres Strait Islander community-controlled peak and member organisations across Australia. See https://coalitionofpeaks.org.au
[6] Australian Governments and the Coalition of Peaks (2020). National Agreement on Closing the Gap. Article 18.

IHACPA has an opportunity to truly seek to change the policy environment by ensuring that Aboriginal and Torres Strait Islander Australians are engaged in a partnership to inform the policy framework that determines the funding model for public hospital services. The pricing framework should include an overarching principle that speaks to Indigenous equity. This should consider equity of access as well as equity of outcomes. It should go beyond equity as a financial concept. At a minimum the Public Hospital Pricing Framework should reference and reflect on how it will meet the policy goals of the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* and the *Closing the Gap Agreement 2020–2025* including the four Priority Reform Areas. It is noted that neither of these major health policies are referenced in the Consultation Paper.

IHACPA should ensure that Aboriginal and Torres Strait Islander service providers and peak bodies such as the National Health Leadership Forum are included. A broad net should be cast to ensure that there is inclusion of researchers and other organisations involved in the research of and delivery of public hospital services to Aboriginal and Torres Strait Islander Australians.

There does not appear to be any Aboriginal and/or Torres Strait Islander Australian representation of the broader IHACPA committees including the Pricing Authority, Clinical Advisory Committee or Stakeholder Advisory Committee. The lack of representation further embeds the invisibility of Aboriginal and Torres Strait Islander Australians in key policy decisions regarding health care.

The Closing the Gap Priority Reform Three relates to addressing racism in mainstream public services. If there are no Aboriginal and/or Torres Strait Islander voices in the vast committee structure of IHACPA then these issues are likely to remain invisible. Aboriginal and Torres Strait Islander interests need to be engaged as full partners in the development, implementation and monitoring of the public hospital pricing framework.

The way in which consultation is conducted further marginalises Aboriginal and Torres Strait Islander peoples. The consultation papers on the pricing framework for Australian public hospitals services are published only In English. It is usually 30-40 pages long and very detailed in nature, it requires a relatively high standard of education to read and make sense of it. This makes it inaccessible to a large proportion of the population but especially for Aboriginal and Torres Strait Islander peoples. English is not the first language for many Aboriginal and Torres Strait Islander peoples and educational levels are significantly lower. Without tailored consultation that account for cultural protocols and other needs, Aboriginal and Torres Strait Islander peoples will continue to be locked out of the policy making process and remain invisible.

In concluding this submission, we note that an agency like IHACPA has understandably seen itself as dealing with technical matters only and that working group and committee membership is driven largely by the jurisdictions. However, there are opportunities for Indigenous representation on key policy committees such as the Clinical Advisory Committee and the Stakeholder Advisory Committee. The work of IHACPA deeply

affects Aboriginal and Torres Strait Islander Australians, and their needs and priorities should be considered within the agency's work. Thus, in line with Commonwealth Government policy, we suggest that IHACPA act to prevent the further marginalisation of Aboriginal and Torres Strait Islander Australians by ensuring that they have a role in the development and implementation of policies that affect them.

Regards

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