Pricing Framework for Australian Public Hospital Services 2025-26 – CHA Submission

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Catholic Health Australia
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Thank you for the opportunity to contribute to the consultation on the Pricing Framework for Australian Public Hospital Services 2025-2026. Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for over 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian state and in the Australian Capital Territory, providing about 25 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care. CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. Our hospitals operate intensive care units (ICUs) across multiple states and territories.

CHA's response to the Consultation Paper

This submission focuses on key elements of the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2025-2026* CHA Members believe warrant further investigation, and is not an exhaustive response to each issue in the *Consultation Paper*.

Issue	Feedback for IHACPA
Chapter 2 – Pricing Guidelines ***Funding transparency and accountability***	Public hospitals receive funding from state and territory governments. This funding is underpinned by a significant contribution from the Commonwealth Government under the National Health Reform Agreement (NHRA). One of the four agreed strategic priorities of the current NHRA is improving efficiency and ensuring financial sustainability. The NHRA also includes commitments to data reporting and calculations of activity and funding, and that this reporting should be accurate, transparent, accountable, and in accordance with the national funding model. This is reflected in the Pricing Guidelines calling out the need for efficiency, fairness and transparency. CHA considers that IHACPA can play a greater role in ensuring these standards are upheld by all parties to the NHRA. There are well-publicised reports of public hospitals struggling with chronic underfunding. To ensure the intent of the NHRA is met, CHA requests that IHACPA begin reporting specifically on any gap between the Commonwealth funding given to states and territories provided under the national funding model and the funds provided to hospitals to provision services. There may be legitimate reasons a quantum of underfunding could exist, but it is clearly the NHRA's intent that states and territories be responsible for explaining any gap. Further, transparency requires that the Australian public be able to readily compare the performance of state and territory governments in keeping the proportion of the health budget spent on administration and other overheads at reasonable levels.
Chapter 3 – Classifications used to describe and price public hospital services	When developing classifications, it is important to recognise that Australian public hospitals do not exist in a vacuum, but as part of a system that includes primary care and a significant private hospital market (providing two thirds of planned surgeries and catering to a significant volume of ED presentations and other hospital admissions).

Engaging early with the private sector	Often, components of classifications developed for the Australian public hospital system are adopted by the private hospital sector. As such, it is appropriate that IHACPA conduct some consultation with the private hospital sector around the applicability (present or future) of new classifications. One example is the new Non-Admitted Care Classification. CHA acknowledges IHACPA's important work as part of the Non-Admitted Patient Classification Project (ANAPP). IHACPA's pragmatic approach to long-term integration with state and territory eMR systems is welcome. However, it is important that CHA conducts, at a minimum, broad education accessible to the private hospital sector on opportunities for it to utilise the ANAPP. This may help inform the private sectors' decisions around its own eMR development and procurement.
Chapter 4 – Setting the National Efficient Price ***Private Patient Neutrality Review***	CHA notes that many public hospitals continue to prioritise utilising private health insurance in public hospitals. This is occurring despite the intention under the NHRA and the Pricing Guidelines (Public-private neutrality) that states and territories not receive financial advantage for utilising private funds. It is conceivable that some of these hospital policies are based on 'inertia' from a time when financial advantage from health insurance utilisation was readily apparent. Nonetheless the behaviour has a distorting impact, and where financial advantage does exist it may well lead to other unintended outcomes including: - The Commonwealth Government contributing in excess of its requirements under the NHRA; - A reduction in funds available for use in not-for-profit hospitals (which have well-established financial challenges at this time) limiting their ability to ease pressure on the public system; and - The creation of a two-tiered system in public hospitals, with those who can afford private health insurance afforded advantages over those who can not. CHA welcomes the IHACPA review of private patient neutrality. CHA asks that in addition to the National Health Funding Body and jurisdictions, IHACPA consult with other public and not-for-profit hospital operators for their views on private patient neutrality.
Chapter 4 – Setting the National Efficient Price ***An adjustment for homelessness***	In previous CHA submissions, we recommended IHACPA explore an adjustment for homeless patients. Homeless patients who present at hospitals often have more complex needs, with underlying chronic/severe conditions that require intensive time and treatment particularly in an Emergency Department setting. This places additional financial strain upon not-for-profit hospitals that are driven by their mission to operate in areas of high disadvantage. Evidence provided in previous submissions highlighted that homeless patients incur a greater length of stay and cost to treat. IHACPA reported in their feedback that they did not believe the evidence was sufficient to warrant an adjustment to the NEP. Further conversations between hospital providers and (then) IHPA indicated that the volume of patients captured in ICD-10-AM data for

	homelessness (coded using 'Z' codes) may not always be adequately captured in the hospital setting. Beginning in July 2021, IHACPA's "Pricing and funding for safety and quality: Avoidable hospital readmissions" policy[1] began adjusting payments to Australian hospitals for avoidable readmissions and titrated the adjustment based on three complexity group levels (low, moderate or high). The risk adjustment models[2] underlying the way IHACPA assigns the complexity levels use numerous factors including number of admissions in the past year, Indigenous status, and patient remoteness. However, they do not capture other social determinants of health domains which may make some patients more socially complex than others. For example, at two CHA member hospitals – St Vincent's in Sydney and Melbourne – more than one-in-three admitted episodes are for socially complex patients, as defined by: - people experiencing homelessness - people in or leaving prison - people who identify as Aboriginal and/or Torres Strait Islander - people experiencing mental illness - people with a dependence on alcohol and/or other drugs - people who require a consultation with a social worker while admitted - people who reside in the lowest two deciles of the Index of Relative Socioeconomic Disadvantage[3] - people with insecure financial resources, employment, food access, environmental conditions - people with a lack of education - people from a cultural and linguistically diverse background - people with a history of living in care Notably, whereas 34% of these patients may be classified as socially complex, they account for: - 47% of total ED visits - 59% of total ED lengths of stay - 69% of total admitted episodes - 83% of total admitted bed days - 69% of non-mental health, alcohol, drugs burden of disease The disproportionate use of acute hospital services by socially complex patients is driven significantly by higher numbers of return presentations rather than longer individual admitted episodes lengths of stay.

[1] https://www.ihacpa.gov.au/sites/default/files/2023-01/ihacpa_avoidable_hospital_readmissions_fact_sheet.pdf

[2] Table 9 from https://www.ihacpa.gov.au/sites/default/files/2022-08/Pricing%20and%20funding%20for%20safety%20and%20quality%20–%20Avoidable%20hospital%20readmissions%202022–23.pdf

[3] https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release#index-of-relative-socio-economic-disadvantage-irsd-

	Research on US Medicare funding models as they impact safety-net hospitals, which are "located in poor and underserved communities"[4] (and hence deliver a high proportion of their care to socially complex patients), notes that: "Poverty, disability, housing instability, residence in a disadvantaged neighborhood, and hospital population from a disadvantaged neighborhood were associated with higher readmission rates. Under current program specifications, safety-net hospitals had higher readmission ratios (AMI, 1.020 vs 0.986 for the most affluent hospitals; pneumonia, 1.031 vs 0.984; and CHF, 1.037 vs 0.977). Adding social factors to risk adjustment cut these differences in half. Over half the safety-net hospitals saw their penalty decline; 4-7.5 percent went from having a penalty to having no penalty. These changes translated into a $17 million reduction in penalties to safety-net hospitals."[5] A recent New England Journal of Medicine[6] article noted: "The discussion should no longer be about the dichotomy of clinical risk versus social risk. If our goal is to align payment with the outcomes we hope to produce, we should acknowledge the interdependence of social, behavioural, and physical domains in constituting risk and producing better health." CHA recommends that IHACPA consider the impact of social determinants of health domains – which may make some patients more socially complex than others resulting in significant hospital readmissions – in its "Pricing and funding for safety and quality: Avoidable hospital readmissions" policy. At the very least, CHA recommends IHACPA return to consideration of a homelessness adjustment in light of the changing economic circumstances facing Australians. Cost of living pressures are contributing to an increase in the number of Australian's experiencing some degree of homelessness or insecure housing which has a proven to have a demonstrable impact on health. As such, the financial burden on hospitals that offer treatment to Australians experiencing either homelessness or insecure housing may have increased. It is important that these particularly vulnerable Australians continue to receive care, and that health services are adequately funded to provide it.
Chapter 8 – Future funding models ***Virtual health care***	Following CHA's comments in the above response to Chapter 4, IHACPA is to be commended for including the private sector at an early stage in IHACPA's work to understand the opportunities around future virtual models of care. CHA looks forward to continuing to contribute to this project and welcomes IHACPA's commitment to ongoing inclusion in consultation as funding models for virtual care develop.

[4] Hefner JL, et al. Defining safety net hospitals in the health services research literature: a systematic review and critical appraisal. BMC Health Services Research (2021) 21:278.

[5] Joynt Maddox KE, et al. Adjusting for social risk factors impacts performance and penalties in the hospital readmissions reduction program. Health Serv Res. 2019; 54:327–336.

[6] Agrawal S and Shrank WH. Clinical and Social Risk Adjustment — Reconsidering Distinctions. N Engl J Med. 2020;382;17